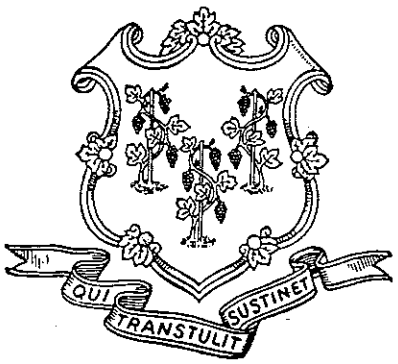
MEDICAID HEALTH SERVICES IN CONNECTICUT

Connecticut

General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

DECEMBER 1994

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the senate, the senate minority leader, the speaker of the house, and the house minority leader each appoint three members.

1993-1994 Committee Members

Senate
Judith G. Freedman
Co-chairman
William A. DiBella
Joseph H. Harper, Jr.
Fred H. Lovegrove, Jr.
Win Smith, Jr.
Kevin B. Sullivan

House
Wade A. Hyslop, Jr.
Co-chairman
Robert D. Bowden
Susan Bysiewicz
Gene Gavin
Kevin F. Rennie
Carl J. Schiessl

Committee Staff

Michael L. Nauer, Ph.D., Director
George W. McKee, Chief Analyst
L. Spencer Cain, Chief Analyst
Carrie E. Vibert, Chief Attorney
Catherine M. Conlin, Principal Analyst
Jill E. Jensen, Principal Analyst
Anne E. McAloon, Principal Analyst
Brian R. Beisel, Associate Analyst
Michelle Castillo, Associate Analyst
Maryellen Duffy, Associate Analyst
Renee La Mark Muir, Associate Analyst
Bonnine T. Klare, Executive Secretary

Staff on this Project

MARYELLEN DUFFY, ASSOCIATE ANALYST
L. SPENCER CAIN, CHIEF ANALYST

STATE CAPITOL ROOM 506 HARTFORD, CT 06106 (203) 240-0300

MEDICAID HEALTH SERVICES IN CONNECTICUT

FINAL REPORT

DECEMBER 1994

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

TABLE OF CONTENTS

MEDICAID HEALTH SERVICES IN CONNECTICUT

EXECUTIVE SUMMARY

Medicaid is a joint federal-state entitlement program that pays for health services on behalf of certain groups of low income persons. Medicaid is administered by states with partial funding by the federal government. Each state has designed its own program within federal guidelines and many states have received waivers to operate programs that differ substantially from federal requirements. States are required to serve certain population groups and provide basic health care coverage, but they also have the option to expand eligibility and benefits. Within federal parameters, states establish reimbursement rates to providers. The Medicaid program varies widely from state-to-state in services provided, program operation, and clients covered.

The department reimburses providers for services rendered with little or no management of care provided to clients. Rather, the focus of the department has been on setting provider rates, processing and paying claims, and verifying eligibility. The program has operated in this fashion since the 1960s. Connecticut has been faced with rapidly rising Medicaid expenditures due to increases in the number of eligible clients, expansion of health benefits, medical price inflation, and increases in the volume of services provided. Although the private health care market has reacted to the escalation of health care costs by adopting a managed care approach, Medicaid as a health program has been slower to respond.

Connecticut is one of the last states to enroll its Medicaid population into managed care health plans. As states wrestle with spiraling program costs and limited state budgets, managed care is viewed as a way in which to slow the growth rate of the program, as well as improve health services. Many states, in order to better control and improve the predictability of expenditure increases, include persons with disabilities and the elderly into managed care delivery systems.

Connecticut's Medicaid program is about to undergo a major transition. Connecticut has lagged behind almost all other states in adopting a managed care program for its Medicaid recipients. Although the department intends to submit a waiver in January 1995 for creation of a mandatory Medicaid managed care program, there have been several delays in meeting their established time-table. Scheduled to begin enrolling clients on July 1, 1995, the program will be changed from a fee-for-service, freedom-of-choice model to pre-paid, case-managed health plans largely administered by private companies. However, it is doubtful Connecticut will be able to meet this date since approval of the federal waiver could take several months.

The current structure of the department is unable to support the managed care initiative. Instead of merely paying claims, the department's role will be primarily a negotiator, purchaser, and overseer of client health services offered in a privately insured but publicly funded health care system. In many ways the department will need to function like a health purchasing

cooperative for the Medicaid population -- negotiating with health plans based on cost and quality and providing members with comparison information about the plans offered.

The minimal staff resources assigned to the initiative so far has caused the department to rely too heavily on an outside consultant for development of the policy and program design. The success of the department's efforts will be dependent on the ability to manage and monitor the program internally and reduce its dependence on consultants. To accomplish this, adequate data bases need to be established which allow for better analysis of health status and expenditure information. This requires the creation of base-line data on Medicaid utilization for before and after program comparisons and encounter-level data that will allow for individual patient tracking over time. From this information the impact of managed health care on the Medicaid population can be measured.

The Department of Social Services will be taking on several regulatory functions for which is has no experience, trained staff, or organizational capacity. Although HMOs are regulated and licensed by the Department of Insurance, two new types of non-HMO health plans not currently existing in Connecticut would be allowed to participate in the program. These plans would be approved solely by the commissioner of social services and would require the department to hire staff with insurance expertise. Although the program review committee found it necessary for the department to have flexibility in developing arrangements that best meet the needs of clients, providers, and insurers, the department lacks the expertise to regulate health insurance entities. Examination of the role of the Department of Insurance in regulating HMOs indicates that many of the responsibilities to be undertaken by the Department of Social Service are being performed within that agency. The Department of Insurance has well-developed systems for reviewing and licensing provider network adequacy and examining the financial solvency of health plans.

Significant policy and program changes will be required in the way health services are paid for and delivered to many of its Medicaid recipients. This change will have important implications for the health care delivery system as large numbers of recipients are enrolled in managed care health plans offered in the private insurance market. The Department of Social Services must redefine their role and accept several new responsibilities. The committee's report identifies major administrative deficiencies that need to be addressed before moving to a managed care program. The recommendations are aimed at enhancing the internal capacity of the department to support the successful transition to managed care and ensure appropriate monitoring once the program is operational.

Recommendations

The Legislative Program Review and Investigations Committee recommends that the commissioner of the Department of Social Services be required to enroll the entire Medicaid population, with the exception of those clients receiving long-term care assistance, into managed care pre-paid health plans. It is further recommended that The Department of Social Services begin enrolling Medicaid clients by July 1, 1995, in compliance with federal

laws and regulations, and that all health services for Medicaid clients, with the exception of long-term care, be provided through pre-paid health plans by December 31, 1997.

The Legislative Program Review Committee recommends the Department of Social Services establish a Managed Care Division within the Health Care Financing Bureau. The division will be solely responsible for administration of the managed care program and be involved in the following functions:

- **evaluating and contracting with prepaid health plans including negotiation and establishment of capitated rates;**
- **assessing quality assurance information compiled by the federally required independent quality assurance contractor;**
- **monitoring contractual compliance;**
- **evaluating enrollment broker performance;**
- **assisting the Health Care Data Institute in establishment of a Medicaid data base; and**
- **providing assistance to the Department of Insurance for the regulation of managed care health plans.**

The division shall be responsible for all aspects of the managed care program. The Department of Social Services shall develop a plan for enrolling the entire Medicaid population, with the exception of long-term care recipients, into prepaid health plans and report to the legislature by February 1, 1996.

The Legislative Program Review Committee recommends a quality assurance unit be established within the Managed Care Division. The unit will be responsible for identification of quality assurance problems and notifying the appropriate entity for resolution. The unit shall develop standards that establish, in advance, expected performance levels for health plans and for the enrollment broker. Performance measures shall be established for four areas -- quality, enrollee access and satisfaction, utilization, and cost.

The Managed Care Division shall develop a system to compare performance levels among health plans and produce a "report card" on each plan providing services. The report card shall be based on the four performance areas established by the department and be published annually.

The Legislative Program Review Committee recommends the Department of Social Services provide the Connecticut Health Care Data Institute with a person-level Medicaid data base. The committee recommends this be accomplished by agreement between the department and the institute. It is further recommended there be established a Medicaid Data Committee to facilitate creation of the data base. The Medicaid Data Committee shall

be composed of the director of the DSS Medicaid Managed Care Division, the Director of the Connecticut Health Care Data Institute, a member of the advisory board of the institute, and representatives from the pre-paid health plans providing Medicaid services. The committee shall be charged with the responsibility for deciding the data elements needed to adequately evaluate health plans, specifications for uniformity, data security and client privacy protection, and the process for providing the data to the institute.

The Legislative Program Review Committee recommends the Department of Social Services contract with the Department of Insurance for the approval and ongoing oversight of all pre-paid health plans providing Medicaid services. The committee further recommends the creation of a joint committee of members from each department for the purpose of developing and regulating Medicaid health plans. No pre-paid Medicaid health plan shall be allowed to operate without approval by the commissioner of insurance.

The Legislative Program Review Committee recommends the department adopt a resource-based relative value system for the purposes of reimbursing health care providers and services. In addition, the department shall adopt a prospective payment system based upon diagnostically related groups for inpatient hospital payments. Each system shall be implemented by January 1, 1996.

The Legislative Program Review Committee recommends that the Comptroller of the state of Connecticut, with the assistance of the Department of Social Services and the Health Care Cost Containment Committee, conduct a study of the feasibility of creating a health insurance purchasing cooperative for state employees, their families, retirees, and Medicaid beneficiaries. The comptroller shall report her findings to the General Assembly by February 1, 1996.

MEDICAID HEALTH SERVICES IN CONNECTICUT

Introduction

The escalation in Medicaid costs, particularly in the 1980s, prompted both the federal and state governments to re-examine program operations and seek innovative alternatives to financing and delivering services to program recipients. In addition to soaring costs, persistent issues of access, quality of care, and provider reimbursement have plagued the Medicaid program for years. In the past, states attempted to contain costs by restricting eligibility, limiting benefits, and maintaining low payments to providers. These efforts met with little success and Medicaid costs continued to spiral upward. In response, states began requiring Medicaid recipients to obtain services through pre-paid managed care health plans and away from a reimbursement system that is based on unmanaged, retrospective fee-for-service health delivery.

Implementation of managed health care, already well established in the private sector, has also become widespread in the public sector in the majority of states. Connecticut, one of the last to embrace this strategy, has begun planning for a managed care program for Medicaid recipients and will start enrolling targeted groups in managed care health plans on July 1, 1995.

The enrollment of Medicaid recipients into managed care health plans will be a major change in policy direction for the state. The role of the Department of Social Services will undergo a significant shift as a major purchaser of health services in a publicly funded but privately delivered market. This report examines the Department of Social Service's plan to move from a fee-for-service health delivery system by enrolling Medicaid beneficiaries into managed care health plans. In order to implement this program, there are several key policy and program design decisions that will have a critical impact on the success or failure of this initiative. Judgments will have to be made concerning: program structure; enrollment processes; quality assurance; provider participation; and reimbursement methodologies.

This report is organized into five sections. Section I presents a description of the federal rules of operation for the Medicaid program. An overview of program's administration in Connecticut is presented in Section II. Sections III examines the delivery of Medicaid health services in Connecticut and Section IV describes the major factors driving health care costs and evaluates strategies for cost control. Section V outlines the Department of Social Services' plan to enroll Medicaid beneficiaries in managed care health plans. Finally, Section VI presents the Legislative Program Review and Investigations Committee's findings and recommendations relative to the operation of Connecticut's Medicaid program.

Section I: Medicaid's Rules of Operation

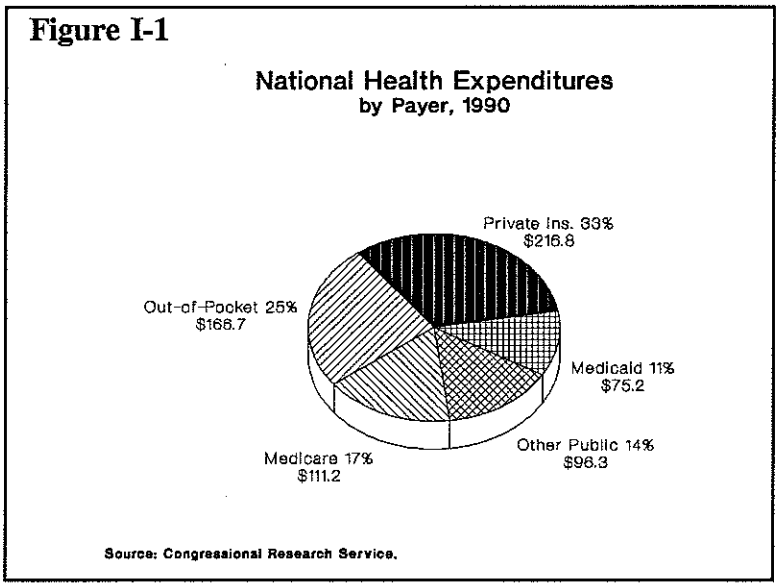
Medicaid Rules

The Medicaid program was enacted by Congress in 1965 to provide medical assistance for certain low income individuals and families. It is a means-tested entitlement program and is jointly funded by the federal and state governments. Although Medicaid does not provide medical services to all poor persons, eligibility for services has been significantly expanded since the program was initially adopted. As a result, expenditures have skyrocketed due to the growth in the numbers served, expansion in the scope of benefits provided, and increases in general health care costs.

Within broad federal guidelines, states have substantial flexibility in the design and administration of the Medicaid program. This has led to extensive variation among states; not only in the persons covered by the program, but also in the type and scope of benefits offered, and reimbursement amounts to providers for services.

Medicaid expenditures in the United States comprised about 11.3 percent of total national health spending in FY 92. Medicaid is the third largest social program in the federal budget, exceeded only by Social Security and Medicare. Figure I-1 shows national health expenditures by payer for calendar year 1990. Private insurance was the greatest source of coverage for health expenditures at 33 percent. Out-of-pocket expenses accounted for 25 percent of total health payments.

Figure I-1



In FY 91, federal and state spending on Medicaid totaled $92 billion and by FY 92, the estimated expenditure rose to $119 billion, a 29 percent increase. In addition, there were an estimated 31.4 million Medicaid recipients in FY 92. Projected dollar outlays will rise to $194 billion in 1996 and may exceed $320 billion by the year 2000.

Eligibility. In general, states are required to provide Medicaid coverage to individuals who receive federally assisted income-maintenance payments - Aid to Families with Dependent Children (AFDC) and Supplemental Security Income recipients (SSI) - as well as certain related groups not receiving cash payments (low-income pregnant women and children who meet specific income and asset limits).

Under Medicaid, coverage groups are divided into categorically needy groups and medically needy groups. Certain populations within the categorically eligible group must be offered coverage, while coverage for others are at state option. Coverage of individuals that qualify within the medically needy category is entirely at state option. There are over 50 statutorily defined population groups; each containing specific income and asset limits that both groups must meet to be eligible for benefits. Furthermore, the distinction between the two types of coverage groups is important because states are allowed to offer each group different scopes of service.

Mandatory categorically eligible groups include those eligible for cash assistance and certain low-income pregnant women and children. Optional categorically needy groups generally are AFDC-related individuals whose income and resources are within AFDC standards, but do not meet qualifying AFDC criteria. The majority of recipients under this category are dependent children whose family income and resources are within AFDC standards, but are not eligible for AFDC because of the requirements under that program that one parent be unemployed, incapacitated, absent, or deceased. The federal government allows, but does not mandate, the state provide Medicaid coverage up to 21 years old.

Persons receiving coverage under a medically needy group have incomes too high to qualify under a categorically needy group otherwise they would be automatically eligible for Medicaid. Medicaid rules allow states to extend coverage if a person's income falls below a set level after medical expenses are paid. If a state offers the program to medically needy groups, the state sets the qualifying levels for income and assets within federal guidelines and then allows an individual to "spend down" to eligibility by incurring medical expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that State's Medicaid plan. This is known as "spenddown" and is allowed only on income, not on assets.

If a state provides Medicaid coverage to medically needy groups, under federal law coverage **must** be provided to pregnant women, including coverage for 60 days following the birth of the child; children under 1 year old whose mother continues to qualify for Medicaid benefits; and children 1 through 18 years old, meeting the medically needy income and asset limits set by the state. Other groups eligible for coverage at the states' option include aged, blind, and disabled persons meeting the state income and asset thresholds.

Federal Reimbursement. The portion of the Medicaid program which is paid by the federal government is known as the Federal Medical Assistance Percentage (FMAP) and is set annually for each state by a formula that compares the state's average per capita income level with the national average. By law the range cannot be lower than 50 percent or greater than 83 percent. Since Medicaid is an entitlement program there is no monetary cap, and the federal government must provide matching funds for whatever expenses are incurred. Connecticut is reimbursed 50 percent by the federal government for its Medicaid expenditures.

Scope of Medicaid Services. All children under 21 years of age who are eligible for Medicaid must receive early and periodic screening, diagnosis, and treatment (EPSDT) services.

Medicaid law requires that even if certain services are not covered under the states' Medicaid plan, they must be provided to EPSDT recipients. In addition, Medicare beneficiaries who also receive Medicaid, must receive any service covered under the Medicare program. For all other coverage groups, Medicaid law draws a distinction between required and optional services. There is a core group of services that must be provided to the categorically needy, as well as a broad range of optional services that states may elect to provide. If states extend coverage to medically needy groups, certain services must be provided. However, these differ considerably from those applicable for the categorically needy group (except for EPSDT and Medicare beneficiaries).

Table I-1 lists the services that must be provided depending on eligibility status. As the table shows, states are required to provide much broader medical services to the categorically needy than those required for the medically needy. However, federal law does not prohibit the same benefit package from being provided. Several states, including Connecticut, do not differentiate between the two groups and provide the same scope of services for both.

States may limit the extent of service coverage to both coverage groups as long as these four federally mandated requirements are met:

- **amount, duration, and scope** - each covered service must be sufficient in amount, duration, and scope to reasonably achieve its medical purpose;

- **comparability** - services available to any categorically needy group must be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the state (similarly, services available to a medically needy group must be equal in amount, duration, an scope to those available to all other medically needy groups);

- **statewide coverage** - amount, duration, and scope of services, must be the same statewide; and

- **freedom-of-choice** - beneficiaries may obtain services from any institution, agency, pharmacy, person, or organization that agrees and is qualified to perform the services.

Optional services. The federal government also allows states to offer additional services to Medicaid recipients. There are 31 categories of optional services that states may elect to provide. Optional services can be provided to categorically needy individuals only, or both categorically and medically needy persons. In Connecticut, an identical benefit package is provided to both groups.

Table I-1. Federally Required Medicaid Services.	
Categorically Needy Services	Medically Needy Services
inpatient hospital services	prenatal care and delivery services for pregnant women
outpatient hospital services	ambulatory services to individuals under age 18 and individuals entitled to institutional services
physician services	home health services to individuals entitled to nursing facility services
nursing facility services for persons aged 21 or older	if coverage is provided for persons in intermediate care facilities for the mentally retarded or services in institutions for mental diseases, all groups covered under the medically needy program must receive 7 of the services provided to the categorically needy.
home health care for persons eligible for nursing services	
family planning services	
laboratory and x-ray services	
pediatric and family nurse practitioner services	
certain federally-qualified health center services and any other ambulatory services offered by a federally-qualified health center and otherwise covered under the state plan	
nurse-midwife services	
early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21	
rural health clinics	
Source: U.S. Department of Health and Human Services - Program and Financial Statistics: Fiscal Year 1991.	

There is tremendous variety among the states, not only in terms of who is covered, but also in the scope of services states have elected to offer. However almost all states cover certain services, including clinic services; prescription drugs; optometrist services and eyeglasses; and dental services. Table I-2 highlights the optional services offered in Connecticut. Of the 31 optional services, Connecticut provides 27.

Table I-2. Coverage of Federal Optional Medicaid Services in Connecticut.	
Optional Services	Covered by CT
podiatrists' services	yes
optometrists' services	yes
chiropractors' services	yes
other practitioners' services	yes
private duty nursing (available to all under Home Health Agency Care)	no
clinic services	yes
dental services	yes
physical therapy	yes
occupation therapy (available through clinic services)	no
speech, hearing, and language disorders	yes
prescription drugs	yes
dentures	yes
prosthetic devices	yes
eyeglasses	yes
diagnostic services	yes
screening services	yes
preventive services	yes
rehabilitative services	yes
age 65 or older in institutions for mental diseases: • inpatient hospital services; • nursing facility services	yes
intermediate care facilities for the mentally retarded	yes
inpatient psychiatric services for under age 21	yes
christian science nurses	no
christian science sanitoriums	yes
nursing facility services for under age 21	yes
emergency hospital services (option available only for hospitals not participating in Medicaid. Service automatically required for participating hospitals, which in CT, all hospitals participate.	no
personal care services	no
transportation services	yes
case management services (targeted for DMR & DMH)	yes
hospice care services (available through home/health care or hospital services)	no
respiratory care services	no
Source: HCFA Pub. No. 02155-92.	

Provider reimbursement. Medicaid operates as a vendor payment program. States pay providers of medical services for care rendered to enrolled individuals. Claims are submitted to the state agency responsible for the Medicaid program where they are processed and payment distributed to the appropriate supplier of services.

Under federal Medicaid law each state retains primary authority to develop provider payment methods and rates. There are, however, three general federal requirements governing reimbursement that apply to all health services. First, payments must be sufficient to ensure that services are as available to Medicaid recipients as to the general public. Second, the Medicaid payment rate must be accepted by providers as full payment. Billing Medicaid clients directly for services is not allowed. Third, state payment methods must be consistent with efficiency, economy, and quality of care. Within the framework of these criteria, states are afforded great latitude in establishing levels of payments.

Medicaid payments can generally be divided into three categories: 1) physician payments; 2) institutional services (hospitals, nursing homes, etc.); and 3) ancillary services such as prescriptions, transportation, eye glasses, and laboratory tests. States are able to establish the unit of payment for services and typically pay per-encounter such as an office visit or hospital stay. However, rates may vary based upon the length of the encounter.

States have four options for providing physician payments. They may establish a **fee schedule** whereby a physician receives an established rate for a specific service or procedure. The fee schedule is typically based upon the historical cost or charge data. States can choose the source of the data, such as a prevailing fee schedule adopted by another organization, to establish the fee schedule. Some states base rates upon the Medicare fee schedule while others simply produce their own.

A second type of physician payment is the **resource-based relative value scale (RBRVS)** system. Under this system, a scale is developed that assigns a numerical value or weight to the amount of resources used by a physician to all procedures and treatments. The system establishes standard quantities of resources needed to treat patients given their diagnosis. The more resources required to treat a particular illness the higher the value. The relative value is then multiplied by a dollar value to establish the fee for a procedure. It eliminates the need to establish a fee for each service. A RBRVS system has been developed by the federal government and is being used to pay for Medicare services. Other states have adopted the Medicare system and tailored it to fit the unique circumstances of their regions.

A third form of reimbursement is to **pay the charges** billed by physicians. Charges may be based upon Medicare limits or may be based upon a percentage of customary and reasonable charges for a given area of service. For some services, such as medical supplies and transportation, paying charges is the usual method of reimbursement.

Finally, state's may develop a **cost-based methodology** that defines what costs are incurred by the physician related to delivering a Medicaid service. Costs can be defined and

computed using Medicare determined cost standards or states can create their own cost definitions. Under this system, states decide which costs they should cover and which they should not. States may further set limits on the payments by agreeing to reimburse for only a portion of the costs rather than full amount.

It should be noted that underlying all these reimbursement methodologies is the fundamental principle that states have limits on funds appropriated for medical services. While this is an area where expenditures often are greater than the appropriated funds, states continually seek ways to reduce outlays in the Medicaid budget. This is done by using various methods to restrict the price charged for medical services. Instead of negotiating fees as is done in the private sector, government payers set fees and let providers decide if they want to accept those fees and Medicaid clients. The problem with rate-setting methodologies is that they have no impact on controlling the utilization of services. This is a widely recognized flaw within the Medicaid system and has resulted in many states moving toward pre-paid health plans where payment is based upon a single rate per person for a given period of time. The revenue received by the health plan is determined by the number of enrollees rather than the amount of services provided and plans must operate within their budgets.

Section II: Medicaid Administration

This section describes the operation of the Medicaid program within the Department of Social Services and its impact on the health care delivery system in the state. A brief summary is provided of the department's day-to-day responsibilities in the program's administration. To understand the growth in the program over the last decade, information is presented about costs incurred and recipients served. In addition, the number and type of health care providers serving Medicaid recipients and the services used are examined. Finally, the relationship between Medicaid and private insurance programs available in the state is explored.

Department Oversight

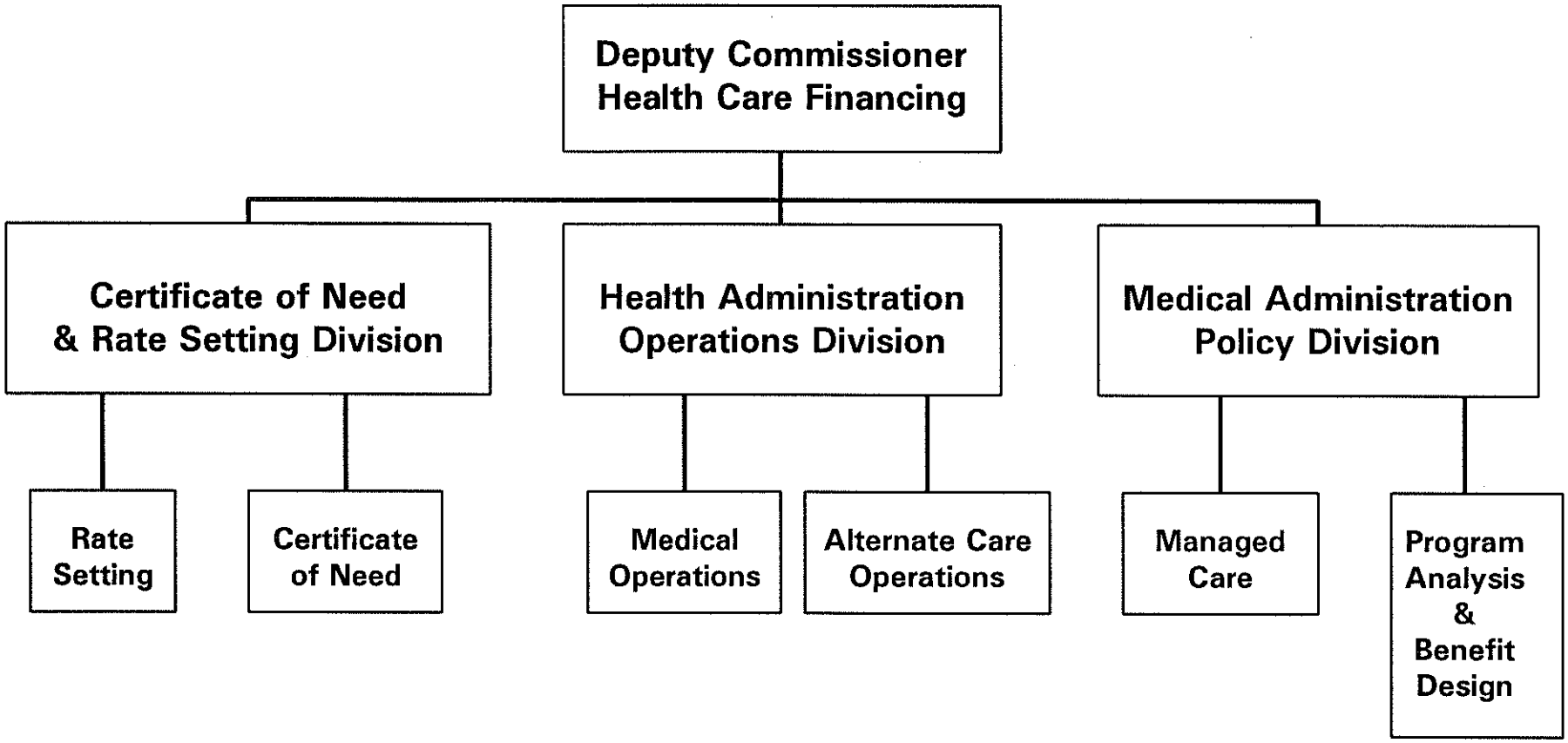
Organization structure. The Medicaid program is administered by the Department of Social Services with the central office responsible for program oversight. Both the financing and policy functions of the Medicaid program are consolidated under the Health Care Financing Bureau, which is headed by a deputy commissioner. The bureau, as shown in Figure II-1, is supported by three divisions -- Certificate of Need and Rate Setting; Medical Administration Operations Division; and Medical Administration Policy Division.

Payment process. Providers bill the department directly for services to recipients. Connecticut pays its providers through a federally approved claims processing system, the Medicaid Management Information System (MMIS). Each bill is subjected to audits to ensure the payment is proper and the information on the claim is correct. This system pays all complete and proper claims within 30 days, processes more than 9 million claims per year and produces over 700 financial and service utilization reports. Before the state will pay a claim, the MMIS ensures that all sources of private insurance are exhausted.

Cost control. The department operates three programs to contain costs and oversee appropriate utilization of medical services. First, the department, in conjunction with the Connecticut Peer Review Organization (CPRO), reviews the medical need for inpatient hospital admissions prior to their delivery. Second, the department and CPRO review utilization to determine whether institutional services provided were medically justified on the basis of an audit of the medical record. Finally, provider utilization is reviewed to uncover patterns of over-utilization or deviant billing patterns.

Applying for Medicaid. In addition to the central office, the department operates six regional offices and eight sub-offices which are directly responsible for determining client eligibility for all social service programs, not only Medicaid. An individual becomes eligible for Medicaid by either directly applying for the program or through their eligibility for another entitlement program. All Aid to Families with Dependent Children (AFDC) recipients, as well as Aid to the Aged, Blind and Disabled (AABD) beneficiaries are automatically eligible for Medicaid and are not required to file a separate application for medical assistance. In either case, income and asset information provided by the applicant are verified by an eligibility

Figure II-1. Department of Social Services:
Bureau of Health Care Financing



worker, and an eligibility determination is made. Computer matches are performed with Department of Labor, Internal Revenue Service, and Social Security Administration data as required under federal law.

Once eligibility is determined, coverage may be retroactive to any or all of the three months from the date of the application as long as the applicant met the income and asset criteria in each of those months. If a recipient becomes ineligible, coverage generally stops at the end of the month in which a person's circumstances change.

Rate-setting in Connecticut

In Connecticut, the Commissioner of Social Service is granted broad authority to establish "a uniform schedule to apply to practitioners of the healing arts and allied professions..." which "... shall be based on moderate and reasonable rates prevailing in the respective communities where the services are rendered" (C.G.S. 4-67c). Reimbursement rates are actually set by two divisions within the Department of Social Services. One, the Certificate of Need and Rate-Setting Division, establishes the rate for hospitals and nursing homes, and the other, the Medical Administration Policy Division, sets rates for all other services. The rate-setting methodology varies depending upon the type of service delivered.

Fee setting by the Medical Administration Policy Division. This division is responsible for setting physicians rates, reimbursement for other health professionals, and fees for a variety of additional services such as transportation, medical and mental health clinics, and medical supplies. The department uses an assortment of methods to arrive at fee schedules for the numerous services and products they cover.

As general policy the department will pay the lower of the following:

- the usual and customary charge to the public;
- the fee as contained in the fee schedule published by the department;
- the amount billed by the provider; or
- the Medicare rate;

In reality, if the department has not developed a fee schedule, it generally reimburses providers at less than the usual charge, the amount billed, or the Medicare rate. Generally, the fees are based upon pre-determined percentage or ratio of either the Medicare reimbursement rate or the reasonable and customary charges for the services.

Fees for physician services are based upon widely accepted procedures codes with the level of payment set at a percentage of the prevailing rate or at 65 percent of what Medicare

pays for the same service. However, many of the physician fees were set more than five years ago and have not been updated.

The only requirement for updating fees comes from the federal government. If access to physicians is being limited by an inadequate fee schedule -- usually defined as less than 50 percent participation by providers -- than the department is required to reevaluate the fee schedule. The department will then bring fees to within 90 percent of the median prevailing private fees. This has most recently been done for primary care, pediatrics, and obstetric services.

Updating thousands of fees is a cumbersome process for the department. Many fees go unchanged for years. Other fees, family planning clinics and outpatient clinics, for example, are required by statute to be updated yearly. This causes an inequity among different providers of health care services and has resulted in a complex rate-making system that lacks a rational pricing policy. The department is attempting to overcome this problem by moving to a relative value based system similar to that used by Medicare. Once established, the system applies a weight to the amount of resources consumed and the department will only have to determine a single dollar value to be applied to the weight. This will result in a simpler method for determining reimbursements as well as keeping fees current based upon the funds available to the department.

Medicaid fees in Connecticut are among the lowest in New England but compare favorably to those of New York and New Jersey. The following table, based upon 1990 data, shows the ratio of Medicaid fees to those in the private sector. However, since 1990, some areas have been increased in Connecticut, particular primary and obstetrical care.

Table II-3. Ratio of Medicaid Fees to Private Fee Levels: 1990.

State	Primary Care	Hospital Visits	Surgery	Obstetrical Care	Lab Tests	Imaging	All Services
Connecticut	.48	.47	.41	.42	.37	.38	.45
Maine	.63	.38	.29	.61	.55	.56	.56
Massachusetts	.84	.61	.48	.65	.41	.49	.70
New Hampshire	.66	.30	.30	.82	.39	.61	.61
Vermont	.75	.71	.59	.58	.60	.49	.67
New Jersey	.41	.22	.19	.22	.28	.32	.33
New York	.27	.14	.12	.38	.15	.34	.28

Sources: Health Insurance Association of America, 1990, "Prevailing Health Care System Charges" and The Urban Institute, 1991, "Survey of 1990 State Medicaid Physician Payment".

Transportation. Transportation services require prior authorization by the department before a client can use the benefit. A provider will not be reimbursed unless prior authorization is granted by the department. Fees for most transportation services are derived from Department of Public Utility Control regulated charges for taxi and livery services. Ambulance fees are based upon state regulations that are implemented by the Department of Social Services. The department has the authority, along with the Department of Transportation, to contract for services with regional transit districts. However, no contracts have been established to date.

Certificate of Need and Rate-Setting Division. The division establishes hospital inpatient rates for all Medicaid clients. The rate methodology is based on a per-case amount to be paid for each hospital stay. The per-case amount may vary by hospital but does not vary by illness, procedure, or diagnosis. There is an adjustment for length of stay, but the amount paid is capped based upon an average length of stay.

The division prospectively sets a cap on the amount it will pay a hospital to cover operating costs incurred in treating a Medicaid patient. Each hospital's cap is based on its 1982 reasonable inpatient operating cost per Medicaid discharge trended forward by an update factor. Thus, 1994 inpatient rates have been updated by an inflation factor each year since the 1982 base rate. The inflation factor was established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and is updated annually by the federal Health Care Financing Administration (HCFA).

Each hospital must submit cost reports identifying the actual operating costs incurred for each patient. If the actual costs are less than the average per-case payment derived by the department then the hospital will be reimbursed for those charges. When the costs exceed the average per case payment, then the hospital receives the average allowed cost. Table II-4 outlines each hospital's average inpatient Medicaid payment and compares it to the hospital's average net revenue operating costs per discharge as established by the Commission on Hospitals and Health Care.

This payment methodology is quite different than the way any other entity reimburses hospitals. Usually hospitals are paid for the amount of services supplied, which is based upon the characteristics of the patients treated. Patients can be hospitalized for a number of different reasons ranging from routine childbirth to open heart surgery. The amount and type of hospital resources varies greatly depending upon the diagnosis and treatment for a particular patient.

Diagnostically related groups (DRGs) were developed to estimate the resources needed for nearly 500 separate illnesses and diseases in order to effectively estimate the cost of services. Most payers use this hospital reimbursement system which incorporates the DRG methodology in their payment mechanisms. Medicare pays hospitals a variable amount per case based upon the resources used by the patient. The resources are determined based upon the patient DRG classification. This differs dramatically from the average per case payments made by DSS on behalf a Medicaid patients.

Table II-4. Average Operating Expense Per Case (AOEPC) vs. Medicaid Cap FY 1992

HOSPITAL	AOEPC	Medicaid Cap Per Case	Medicaid Cap as a % of AOEPC
WINSTED	$5,983	$4,844	81%
YALE-NEW HAVEN	7,117	3,724	52%
GREENWICH	6,284	3,679	59%
NORWALK	7,050	3,516	50%
HARTFORD	5,761	3,427	59%
ST VINCENT	5,061	3,173	63%
ST RAPHAELS	6,077	3,075	51%
WATERBURY	6,544	3,010	46%
MOUNT SINAI	6,536	2,982	46%
ST JOSEPH	7,063	2,853	40%
LAWRENCE & MEMORIAL	5,046	2,818	56%
ST FRANCES	5,126	2,616	51%
JOHNSON MEMORIAL	5,695	2,553	45%
BRIDGEPORT	5,838	2,528	43%
STAMFORD	6,641	2,495	38%
ROCKVILLE	4,929	2,357	48%
GRIFFIN	5,906	2,321	39%
ST MARY	5,693	2,258	40%
MANCHESTER	5,095	2,254	44%
BRISTOL	4,888	2,222	45%
MIDDLESEX	4,967	2,221	45%
DANBURY	5,913	2,206	37%
BACKUS	4,648	2,161	46%
NEW BRITAIN	5,080	2,127	42%
MILFORD	5,480	2,124	39%
SHARON	6,086	2,069	34%
BRADLEY	5,122	1,919	37%
DAY KIMBALL	5,300	1,899	36%
WINDHAM	5,322	1,852	35%
HUNGERFORD	5,291	1,793	34%
NEW MILFORD	5,305	1,029	19%
STATE AVERAGE	$5,705	$2,584	45%

Medicaid Payments Challenged. As Table II-4 indicates, there is a substantial variation between a hospital's operating expenses and the Medicaid payment. The Medicaid payment can be as high as 80 percent of the per patient operating expense (Winsted Hospital), or as low as 19 percent at New Milford Hospital. The state average is 45 percent. This disparity has resulted in a lawsuit filed by the Connecticut Hospital Association against the state of Connecticut over the department's rate-setting methodology (Connecticut Hospital Association, Et. Al. v. William O'Neill, Et. Al.).

The court challenge resulted in the U.S. District Court recently ruling Connecticut's Medicaid reimbursement system invalid. The state has appealed the judges' decision and the case is currently under review. The challenge is based upon a 1980 federal amendment to Medicaid law, known as the Boren Amendment, which says that reimbursement rates should be reasonable and adequate to meet costs incurred by "efficiently and economically" operated facilities. The judge found the department failed to establish a connection between the operational costs of hospitals and the reimbursement rates under the state system.

The department contracted with the First Chesapeake Group to study the adequacy of the hospital rates. Based on the study's findings, the department contends that most of Connecticut's hospitals are not operating efficiently and thus the reimbursement rates are adequate. The study calculated a variety of financial ratios based upon cost data submitted by all hospitals to HCFA. The study developed standardized rankings of all hospitals and compared Connecticut with all other New England and New York facilities. Those operating at or above the 90th percentile were classed as high financial cost hospitals and those operating at or below the 10th percentile were low cost facilities. Based upon these financial ratios, Connecticut consistently ranked high against similar hospitals in the other states. In fact, the study found that no Connecticut hospital was ranked below the 10th percentile for a composite operating cost ratio. The department considered hospitals operating at or below the 10th percentile to be operating efficiently. Only a few Connecticut hospitals operated at the 15th and 20th percentile, when compared with other hospitals, and the department concluded there is potential for greater efficiency in Connecticut's hospital system. A more efficient hospital system would produce charges closer to the payments being made by the department.

Although the case is still within the courts, it illustrates the problems inherent within the rate-setting methodology. The state's system of Medicaid payments makes no adjustment for case severity nor does it take advantage of differences in hospital efficiencies that could lead to lower costs. Rather, payments are based upon historical rates, established in 1982, that may no longer represent current system costs. Medicaid payment systems have been much slower to adapt to recent health cost-containment methods, such as aggressive utilization review, whose effectiveness has been demonstrated by private sector initiatives. Medicaid is still largely a fee-for-service system with payments. While some services require prior authorization by DSS, there is little direct control over utilization. Managing patient care and sharing risk with providers has yet to be introduced in the Connecticut Medicaid system. This is however changing and will be discussed in the next section.

Section III: Medicaid Health Services in Connecticut

The health care delivery and finance system in Connecticut is a complex array of dollars, services, and people. The financing and delivery of Medicaid services by the state is an integral part of this system. In considering how services are provided it is important to understand the environment in which health care is delivered. Connecticut is unique in a number of areas, particularly health care access and cost, and the Medicaid program should be analyzed with these factors in mind. The following examines the nature of Connecticut's delivery system and its relationship to the Medicaid program. Also considered are the composition of health expenditures, the expansion of costs, the Medicaid marketplace, and the impact the growth of pre-paid health plans has on the delivery of services.

National Comparisons

Access to Health Care in Connecticut. Connecticut has one of the nation's best records in terms of access to and coverage for health care services. The state ranked second in 1992 in percent of the population covered by health insurance. (Connecticut had 8.1 percent uninsured, tied for second with Minnesota; Hawaii ranked first at 6 percent.)[1] In addition, Connecticut ranks first in lowest rate of children uninsured (5 percent), again tied with Minnesota.[2] One of the reasons for the low rates is the expansion of the Medicaid program to certain children living above the poverty level.

Access to primary care services also ranks quite high in Connecticut. Based on information collected by the U.S. Department of Health and Human Service's Bureau of Primary Health Care (Division of Shortage Designation), Connecticut ranked first in 1992 and fourth in 1993 in access to primary care. The division measures the percent of the population underserved by primary care practitioners and designates health manpower shortage areas throughout the United States. Its designation is based upon the ratio of primary care physicians to population within specific geographic areas. Connecticut is well above the national average for both years. The following table, III-1, portrays the top five states with the lowest population percentages lacking primary care access.

Medicaid costs. A comparison of national per capita costs for those receiving Medicaid shows Connecticut, on average, expends significantly more than other states. Table III-2 presents the top and bottom five states for average program cost per recipient. The table shows Connecticut's costs were among the highest in the nation in 1991, ranking first in Medicaid expenditures per recipient at $5,994. The state fell to second place behind New York in 1992

---

[1] U. S. Census Bureau, *Money Income of Households, Families and Person in the United States: 1992*, September 1993.

[2] Diana Gordon, *Hush Little Baby, Don't Get Sick*, **State Legislatures (NCSL)**, September 1994, p. 22.

when costs per recipient actually dropped to $5,258. Connecticut's Medicaid costs are nearly double the national average.

Table III-1. Percent of the Population Lacking Access to Primary Care: 1992 & 1993.

1992			1993		
Rank	State	Percent	Rank	State	Percent
1	Connecticut	2.1	1	Hawaii	2.8
2	Hawaii	2.4	2	Maryland	3.8
3	New Hampshire	2.6	3	New Hampshire	3.9
4	Kansas	3.1	4	Connecticut	4.2
5	Minnesota	4.2	5	Delaware	4.2
	National Average	8.3		National Average	9.5

Source: U.S. Department of Health and Human Services, Bureau of Primary Health Care, Division of Shortage Designation, Bethesda, Maryland.

Table III-2. Medicaid Cost Per Recipient: 1991 & 1992. Top Five and Bottom Five States

1991			1992		
Rank	State	Cost	Rank	State	Cost
1	Connecticut	$5,994	1	New York	$5,975
2	New York	5,577	2	Connecticut	5,258
3	New Hampshire	4,898	3	New Hampshire	4,779
4	New Jersey	4,437	4	Massachusetts	4,733
5	Massachusetts	4,344	5	North Dakota	4,430
	National Average	**2,725**		**National Average**	**2,936**
46	Alabama	1,997	46	Tennessee	2,210
47	West Virginia	1,912	47	Texas	2,177
48	California	1,886	48	California	1,938
49	Mississippi	1,607	49	Mississippi	1,809
50	Arizona	268	50	Arizona	520

Source: U.S. Department of Health and Human Services, Health Care Financing Administration (Statistical Report on Medical Care: Eligible, Recipients, Payments and Services: HCFA-2082)

Connecticut's costs were also the highest in the nation in 1991 for two categories of beneficiaries; children living in low-income families and the aged. While the national averages for payments to children was $902 and $7,617 for the elderly, primarily for long-term care, Connecticut made payments of $1,750 and $19,278, respectively. The state's payments for long-term nursing home care clearly have a powerful impact on average overall expenditures.

There are several factors that may explain why Connecticut expenditures exceed the U.S. average. The types of individuals receiving Medicaid, as well as the amount, duration, scope, and cost of services are quite varied among states. Connecticut provides several optional services to mandatory and numerous optional coverage groups, which may also account for the difference. The factors influencing Medicaid costs and ways for controlling expenditures are explored in detail in the next section.

Growth in Connecticut's Medicaid Program

Connecticut has experienced tremendous growth in its Medicaid program, both in terms of dollars expended and recipients served. Figure III-1 shows total expenditures (including long-term care) over a nine-year period. In 1985, total Medicaid expenditures were $493,738,772. Of this, persons who either qualified for AFDC, or fell into an AFDC-related category, represented about 24 percent of the total expenditure. By 1993, total Medicaid expenditures were estimated at $1,481,870,000. This represents a 200 percent increase over the nine-year period.

Figure III-1

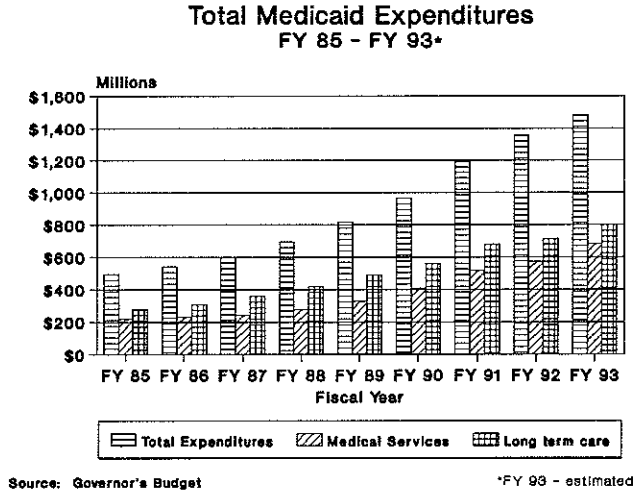
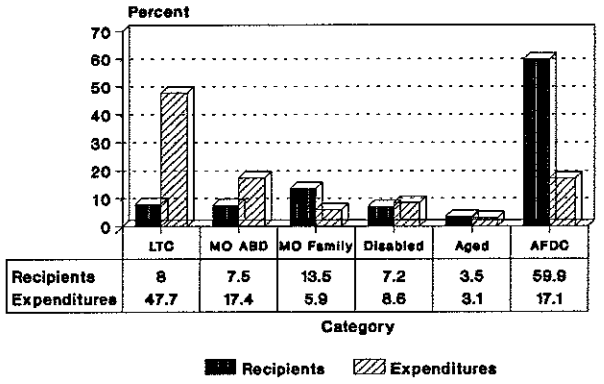


Figure III-1 also shows the portion of resources that went for long-term care versus medical services. Included in the medical services category are inpatient hospital, outpatient, clinics, home health, transportation, dental, vision care, and a variety of other medical services. Over the nine-year period, long-term care costs have consistently accounted for 50 to 60 percent of total resources. Between FY 85 and FY 88, the rate of growth in long-term care expenditures exceeded those of medical services. However, from FY 89 to FY 93, year-to-year increases in the cost of medical services grew at a faster rate, increasing 27 percent from FY 90 to FY 91.

The relationship between the number of recipients and the share of payments for each eligibility group in Connecticut for the month of June 1992 is presented in Figure III-2. AFDC and AFDC-related recipients comprise approximately 60 percent of eligible recipients; however

they accounted for only 23 percent of Medicaid expenditures in June 1992. Conversely, only 8 percent of Medicaid recipients receive long-term care services, but they account for almost 50 percent of expenditures.

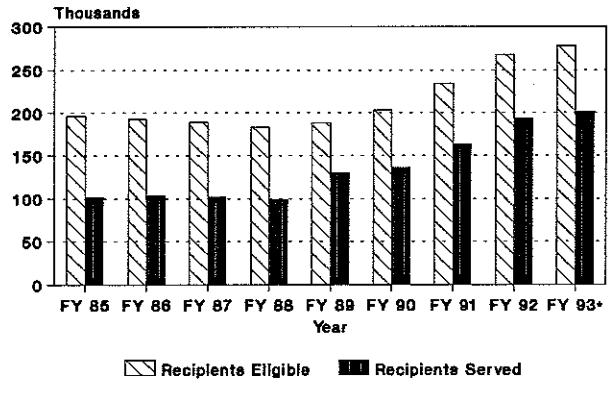
Figure III-2



Payments and Recipients for June, 1992.

Figure III-3 shows the number of persons eligible for Medicaid and compares them to the number actually served over the same time period. Not all individuals who are covered by the Medicaid program actually use the services. Overall, there was a 41 percent increase in the number of individuals eligible for Medicaid for the nine-year period. However, the number of persons that were actually served by the program increased by 98 percent over the same period.

Figure III-3



Source: Governor's Budget. *estimated

Recent Growth. The total cost of Connecticut's Medicaid program has also grown significantly over the past four years. In fiscal year 1991, the state spent a total of $1.19 billion for all Medicaid services with spending increasing to $1.61 billion by fiscal 1994, representing a 35 percent increase in the four-year period. In comparison, the state general fund budget was $7,705 billion for FY 91 and is estimated to have reached $9,259 billion for FY 94[3] representing an increase of 20 percent.

Medicaid expenditures can be broken down into two categories -- health services and long-term care. Health services includes all the areas of benefit coverage such as hospitals care,

[3] Connecticut State Budget 1993-95 Revisions, Office of Fiscal Analysis, Connecticut General Assembly, July 1994, p. 9.

physician, labs, and drugs. Long-term care, primarily payments for nursing homes, is represented as a separate category. As shown in Table III-3, total growth in the health services category over the four years examined was 48.9 percent -- more than double the rate of growth in state general fund expenditures. The table indicates that the largest expenditure increases occurred in the category of health services for both AFDC recipients, and aged, blind, and disabled beneficiaries, the latter growing at the greatest rate.

The table also shows the increase in expenditures for each population group and the type of service provided. The AFDC and related groups experienced the greatest rate of growth at 44 percent. Part of this growth is due to the expansion of eligibility for certain categories of children.

Table III-3. Connecticut Medicaid Expenditures: FY 91 v. FY 94.

Fiscal Year '91	AFDC & Related Groups	Aged, Blind & Disabled	Total
Health Services	$254,602,585	$259,242,319	$513,844,904
Long-term Care	6,103,169	673,102,331 (565,768,450)[1]	679,205,500
Total	**260,705,754**	**932,344,650**	**1,193,050,404**
Fiscal Year '94			
Health Services	367,224,479	398,257,705	765,482,184
Long-term Care	8,550,855	836,924,483 (703,038,450)[1]	845,475,338
Total	**$375,775,334**	**$1,235,182,188**	**$1,610,957,522**
Percent Change: '91-'94			
Health Services	44.23%	53.62%	48.97%
Long-term Care	40.11%	24.34%	24.48%
Total	**44.14%**	**32.48%**	**35.03%**

[1] This amount represents expenditures for the aged only which is primarily used for Nursing homes.

The Medicaid Marketplace

Like many other health insurance programs, understanding the Medicaid program -- who it serves and who provides services -- is based upon four key characteristics: 1) regulations governing the program's operation; 2) eligibility for the health plan; 3) benefits, coverage, and payments; and 4) access to services. As noted earlier, the Medicaid program is governed by a

wide array of state and federal laws and regulations detailing who is eligible and what Medicaid covers.

In terms of health benefits, Medicaid is generally more comprehensive than most commercial insurance plans because it includes such benefits as dental, vision, and transportation. In addition, there are no copayments or deductibles associated with program; clients are not faced with any additional costs. However, like other health plans that have moved toward managing the care of their patients, access to providers is limited. In the case of Medicaid, the reluctance of providers to accept low fees has limited access. However, any licensed provider who is willing to accept Medicaid fees for covered services can be chosen by a recipient.

The Medicaid program represents a substantial share of the overall health care market. The health insurance market is composed of a diverse mix of government payers, commercial insurers, health maintenance organizations, Blue Cross/Blue Shield, and self-insurers. Table III-4 provides a breakdown of enrollment by health plan. Combining long-term care and health services results in Medicaid accounting for 8 percent of the total insurance enrollment in Connecticut. Besides Medicare and Blue Cross, Medicaid represents the third largest single

Table III-4. Estimated Health Insurance Enrollments: 1992[4]

Form of Insurance	Market Share	Estimated Enrollment
Medicare	15%	485,229
Medicaid	8%	256,515
Long-term Care	*1%*	*21,201*
Health Services	*7%*	*235,314*
HMOs	20%	635,438
Blue Cross	23%	723,469
Commercials	17%	546,089
Third-Party Administrators	12%	394,816
Coalition of Taft-Hartley Health Funds	4%	132,000
Total	100%	3,173,556

[4] These numbers are derived from a variety of sources and estimates of actual enrollment. Commercial and Blue Cross/Blue Shield estimates are based upon average premiums per employee for preferred provider insurance plans, as reported by Foster & Higgins ($4,246) multiplied by 2.285 (the average household size in Connecticut). Other estimates were provided by organizations representing third-party administrators and Taft-Hartley funds. There is some double counting in that one household may purchase multiple or supplemental insurance plans.

health insuring entity in the state and thus can be extremely influential in affecting change in the marketplace.

Table III-5 shows that Medicaid expenditures, taken as insurance premiums, represent the second highest growth category of any insurance entity. The growth of Medicaid is due both to increases in the caseload and expenditures for services. Health services within the Medicaid program is the fastest growing category, at 126 percent, when compared to other health insurance premiums over the five-year period.

HMOs have experienced the next largest growth over the period and have begun to push health care in Connecticut towards managed care. Over the five-year period, HMOs nearly doubled, while Blue Cross indemnity insurance increased by only 17 percent and commercial insurers increased by 19 percent. The federal government's Medicare program is the third fastest growing health plan in the state.

Table III-5. Health Insurance Premiums: 1988 to 1992

Insurance Entity	1988	1989	1990	1991	1992	'88-'92 Percent Change	'92 Market Share
Medicare	$1,147,000	$1,310,000	$1,494,000	$1,612,000	$1,953,460	70%	24%
Medicaid	693,815	816,500	964,800	1,195,800	1,339,800	93%	16%
Long-term Care	*416,997*	*489,420*	*559,004*	*515,650*	*713,536*	*71%*	*9%*
Health Services	*276,818*	*327,080*	*405,796*	*680,150*	*626,264*	*126%*	*8%*
HMOs	519,171	703,401	854,351	942,884	1,034,337	99%	13%
Blue Cross	1,152,641	1,343,647	1,406,247	1,388,693	1,344,355	17%	17%
Commercials	941,166	1,075,189	1,270,618	1,091,932	1,123,724	19%	14%
Total w/o LTC	*4,730,611*	*5,575,817*	*6,395,812*	*6,911,459*	*7,421,940*	*57%*	*89%*
Total	$5,147,608	$6,065,237	$6,954,816	$7,427,109	$8,135,476	58%	100%

The table does not include any self-insurance funds, except those that are included in the Blue Cross premiums.

Who is Covered by Medicaid. As noted earlier, the Medicaid program generally covers certain qualifying individuals and families living at or below the poverty line, individuals who are aged, disabled, or blind, and individuals who face extraordinary medical expenses and are forced to spend most of their assets. Table III-6 breaks down Medicaid enrollment into three groups: 1) those receiving AFDC payments and those with related circumstances; 2) those

receiving long term care; and 3) those receiving assistance as a result of age, being disabled or being blind.

As the table indicates these three distinct categories of Medicaid clients differ significantly in terms of expense. The least costliest, but the largest in terms of enrollment, is the AFDC caseload. The costliest category, at $33,655 per client, is that group of individuals receiving long-term care, primarily the elderly living in nursing homes. Finally, the aged, blind, and disabled group is one-fourth as large as AFDC category but consumes five times the resources on an individual basis. Providing health services for the disabled represents the largest share of this category. Developing solutions to rising Medicaid costs will require that each of these categories be dealt with differently given the special needs of each population.

Table III-6. Medicaid Enrollment and Expenditures: FY 92.

Category	Enrollment	Expenditures	Average Cost Per Enrollee
AFDC & Related Groups	188,685	$ 282,149,149	$ 1,495
Long Term Care	21,201	$ 713,536,487	$33,655
Aged, Blind, & Disabled	46,629	$ 344,114,962	$ 7,379
Total	256,515	$1,339,800,598	

Medicaid clients are geographically dispersed throughout every town in the state, although there is a high concentration of clients in cities. In fact, 80 percent of the total Medicaid eligible population[5] resides in 20 towns. Table III-7 presents the top 20 towns and the clients in each.

Medicaid Benefits and Health Services. Medicaid provides an array of health services ranging from primary and specialist care to dental services to inpatient and outpatient visits. The department supplied the program review committee staff with a database covering the services provided AFDC and related groups for fiscal year 1993. Analysis of the database reveals the number of providers, number of patients, and the cost attributable to those patients by each service category.

Program review staff combined 90 service categories into the following classes: 1) medical supplies; 2) transportation; 3) medical clinics; 4) dental; 5) other health services; 6) mental health; 7) pharmacy; 8) primary care; 9) specialists; 10) inpatient services; and 11) outpatient services. Table III-8 summarizes the total expenditure for each category, the number

[5] Includes only the AFDC and related groups (AFDC unemployed, categorically needy families, and medically needy families.)

of patients served, and the number of claims paid. As the table indicates, inpatient and outpatient expenditures are by far the largest categories of service.

Table III-7. Medicaid Eligible Clients: Top Twenty Towns (September 1993)

Town	Clients	Percent of Total
Hartford	39,491	19.3%
Bridgeport	23,883	11.6
New Haven	23,887	11.6
Waterbury	14,943	7.3
New Britain	9,900	4.8
Meriden	5,935	2.9
Stamford	5,470	2.7
Norwalk	4,239	2.1
West Haven	4,096	2.0
Danbury	3,874	1.9
Norwich	3,709	1.8
East Hartford	3,630	1.8
New London	3,412	1.7
Bristol	3,064	1.5
Windham	2,937	1.4
Middletown	2,763	1.3
Montville	2,649	1.3
Manchester	2,635	1.3
Vernon	1,660	0.8
Hamden	1,518	0.7
subtotal	163,695	80%
All Towns	204,566	100%

Medicaid Providers. Theoretically, all licensed providers are part of the Medicaid health "network". However the number of providers is limited to those willing to accept the level of payment which is considerably less than they would otherwise receive for services from most non-government payers. Providers are not allowed to bill patients for any remaining balance and thus must accept Medicaid's fees as full payment.

Table III-8. Analysis of Medicaid Health Services.

Classification	Total Expenditures	Total Patients Served	Total Claims Paid
Medical Supplies	$4,021,101	10,071	23,565
Transportation	$6,208,667	44,512	154,957
Medical Clinic	$9,401,420	48,016	143,477
Dental Services	$10,025,229	96,583	192,294
Other Health Services	$16,243,793	119,698	261,465
Mental Health	$19,429,111	17,913	93,889
Pharmacy	$20,220,486	258,414	1,046,228
Primary Care	$24,708,343	125,811	373,772
Specialists	$13,918,334	149,165	290,160
Outpatient	$60,982,032	175,347	569,076
Inpatient	$108,804,310	31,312	37,006

Table III-9 outlines the number of providers serving the Medicaid population. The table presents all providers who served Medicaid clients as well as those who had more than 10 patients. As the table indicates, there is a substantial drop-off in almost every category when providers seeing less than 11 Medicaid clients are eliminated.

Primary care physicians and specialists participating in the Medicaid program are less than half that of all Connecticut practicing physicians. There are approximately 1,961 primary care physicians[6] in the state of which only 42 percent are actively providing services to Medicaid clients. That rate declines to 34 percent when only those physicians with a caseload in excess of 10 patients is considered. The rate for specialist participation is even lower, with

[6] Primary care physicians are defined as family/general practice, pediatrics, obstetrics and gynecology.

37 percent of all providers (5,995) seeing Medicaid patients and only 20 percent seeing more than 10.

Table III-9. Medicaid Providers by Type of Health Services.

Classification	# of Providers	Providers with more than 10 Patients
Medical Clinic	27	25
Dental Services	800	467
Other Health Services	840	494
Mental Health	383	158
Primary Care	834	667
Specialists	2244	1202
Outpatient	163	45
Inpatient	106	47

Medicaid clients receive a significant amount of care, both primary and specialist, from community medical and outpatient clinics. There are 27 medical clinics serving over 48,000 Medicaid patients. However, the largest source of primary and specialist care comes from outpatient clinics located mostly at Connecticut hospitals. Outpatient clinics were visited by 175,000 Medicaid clients[7]. Twenty-nine Connecticut hospitals were visited by more than 1,000 AFDC Medicaid patients during fiscal year 1993. Table III-10 lists 15 hospital-based outpatient clinics which account for 72 percent of all patient visits.

Table III-10. Outpatient Clinics Serving Medicaid Clients.

Clinic	Patients	% of Total
Hartford Hospital	19,187	10.9%
Yale-New Haven Hospital	16,005	9.1
St. Francis Hospital Medical Center (Hartford)	14,470	8.3
Bridgeport Hospital	12,870	7.3

[7] This number may include duplicate clients. A client visiting more than one outpatient clinic would be counted twice. The number of patients is unique only to a single facility.

Table III-10. Outpatient Clinics Serving Medicaid Clients.		
Clinic	Patients	% of Total
St. Mary's Hospital (Waterbury)	11,371	6.5
Mount Sinai Hospital (Hartford)	8,623	4.9
Park City Hospital (Bridgeport)	7,503	4.3
New Britain General Hospital	7,393	4.2
Hospital of St. Raphael's (New Haven)	7,315	4.2
Veteran's Memorial Medical Center (Meriden)	5,857	3.3
Waterbury Hospital	5,599	3.2
St. Vincent's Medical Center (Bridgeport)	5,173	2.9
Lawrence & Memorial Hospital (New London)	4,905	2.8
Danbury Hospital	4,364	2.5
William Backus Hospital (Norwich)	3,886	2.2
subtotal	134,521	76.7
Total	175,347	100%

Understanding the way Medicaid services are delivered is important to knowing how the state will move the program into a managed care system. The following section describes the general features of managed care, its growth in Connecticut, and how Medicaid will be transformed from its current state administered fee-for-service operation to private sector health plans.

Health Plans and Managed Care In Connecticut

Health plans are a comprehensive approach to health care delivery and financing. Health plans are concerned with ensuring quality, access, and cost-effectiveness for health care consumers, as well as for providers and payers. An integrated health plan can be defined as:

- an organization that has a legal responsibility to deliver medical services to enrolled consumers who seek care from within a network of providers employed by or under contract with the plan;

- an organization that manages care by controlling the patterns of practice of providers in the network through administrative and financial controls; and

- an organization that shares the risk of health care by agreeing to provide services to members on a fixed rate-per-person for a given period of time (usually referred to as the capitated rate).

Financing health care in Connecticut has undergone a transformation over the past decade. The market has moved gradually from health risk underwritten through indemnity insurance plans on a fee-for-service basis to managed health care plans with negotiated arrangements for paying claims to networks of providers based upon negotiated fees. Unrestricted payments to providers by third-party insurers are widely recognized as a major contributor to growth rate in health care costs. The primary feature of the new arrangements is the linking of health care finance to the management and delivery of health services.

Cost containment. The key to the development of health plans with cost containment strategies involves the organizational structure of service delivery and insurance. The emphasis is on controlling both the price of services as well as the number and intensity of services used. Health plans have been moving toward integrated delivery systems to better control price and utilization.

Organizations offering health plans have adopted two means for controlling costs: 1) managed care and utilization review mechanisms which impose direct controls on unnecessary or inappropriate care; and 2) selectively contracting with providers who have demonstrated a willingness to limit fees, maintain an appropriate style of practice, and share a portion of the risk for a patient's health. These features of organized health plans -- negotiating fees, managed care, and selective contracting -- represent the core processes for cost containment among private health plans.

Managed care health plans administer the delivery of health care services to enrollees through contracts maintained with physicians, specialists, hospitals, pharmacies, laboratories, and other health care providers. The contractual arrangements usually include fixed monthly fees per enrollee or other risk sharing arrangements that give providers a financial incentive to avoid unnecessary utilization of hospital, physician, and ancillary health care services.

Table III-11. Continuum of Insurance Plans for Health Delivery.

Indemnity Insurance: Unmanaged/Fee-for-Service Managed Care Utilization Review	Preferred Provider Organizations (PPOs)	Health Maintenance Organizations (HMO)

Private health plans can be divided into three broad classes: 1) unmanaged/managed indemnity plans; 2) preferred provider organizations; and 3) health maintenance organizations. Table III-11 illustrates the range of organizational entities and their involvement in various cost containment strategies.

Indemnity. Indemnity insurance plans allow for freedom of provider choice and reimburse on a fee-for-service basis. The state's Medicaid system most closely represents this type of insurance plan. Under fee-for-service plans (FFS), a portion of the costs are covered and participants have considerable range in their choice of providers. FFS plans typically have deductible amounts which the insured person pays as well as maximum out-of-pocket expenses, both of which are absent from the Medicaid program. FFS plans usually pay a specified percentage of the allowable provider charges, with the insured responsible for the balance of the bill. Again, balanced billing of Medicaid clients is not allowed. The more services offered, the more charges incurred and the more revenue generated for the provider. Fee-for-service represents a powerful disincentive for controlling utilization in the health care system. The current Medicaid system contains most of the indemnity plan characteristics.

HMOs. At the other end of the continuum, as displayed in Table III-11, are health maintenance organizations which directly combine financing with the delivery of medicine. HMO participation provides financial protection for the consumer with very little cost sharing. It does, however, require that medical care be provided by a designated network of providers. The networks can include staff model HMOs or group model HMOs that contract with multi-specialty medical groups to provide services to members. In Connecticut, the most prevalent model HMO is a third type that contracts with independent practice associations composed of individual practitioners who agree to provide services to the members. This is the model most likely to be used for the Medicaid program.

HMOs provide comprehensive health care services to clients for a fixed monthly premium charged to the group (capitated rate). The monthly premium does not vary with the nature, frequency, or cost of services provided. Rather the HMO is required to provide those services within the cost contained environment of a fixed health budget for the group insured. Establishing this fixed monthly charge will be one of the key features for containing costs in the Medicaid program. The Department of Social Services will be responsible for initially determining the capitated rate. In the future, the market place may determine this rate through competitive bidding.

Managed care in Connecticut. Managed care has grown significantly over the past five years based upon total premiums and enrollment in HMOs. In addition, as Table III-12 indicates, HMO enrollment has grown by 69 percent over six years, with a total market share second only to Blue Cross. Recently, Blue Cross has begun to move a large share of its business into a new HMO, the Enterprise Health Plan, which will further erode the base for indemnity insurance.

Managed care systems take three basic legal forms in Connecticut: health maintenance organizations, organized under the provisions of the federal HMO Act of 1973; preferred provider organizations, organized as insurers; and licensed indemnity insurers who contract with a utilization review company. All are regulated by the state Department of Insurance and are required to meet minimum capitalization and reserve standards. Each is audited for financial solvency on a continual basis by the insurance department.

Connecticut has a strong and growing managed health care market. While it is not certain that all of the currently licensed HMOs will participate in the Medicaid program, Medicaid clients do represent a significant source of new business. Those organizations that do participate could significantly increase their market share. Competition for patients already exists in this market and that competition could be used to contain increases in Medicaid expenditures. However, the unique characteristics of the medicaid population will require other providers to be included in HMO networks, particularly providers in urban areas. As an earlier table indicates, more than 50 percent of the Medicaid population resides in five cities. Connecticut's HMOs are closely monitoring the state's transition toward managed health care and will be offered the opportunity to participate.

Table III-12. Health Maintenance Organizations: Enrollment.

	1988	1993	1994	Percent Change 93-94	Percent Change 88-94
AETNA HEALTH PLANS OF SNE	4,617	43,806	64,898	48%	1,306%
BLUE CARE HEALTH PLAN	NA	NA	78,151	NA	NA
CIGNA HEALTH PLAN OF CT	47,303	80,772	130,543	62	176
COMMUNITY HEALTH CARE PLAN	71,940	44,907	43,732	-3	-39
CONNECTICARE	62,842	118,594	110,369	-7	76
CONSTITUTION HEALTH NETWORK	158,538	85,557	91,763	7	-42
KAISER FOUNDATION HEALTH PLAN	38,006	46,329	44,518	-4	17
M.D. HEALTH PLAN	8,144	78,524	113,026	44	1,288
OXFORD HEALTH PLAN	NA	NA	320	NA	NA
PHYSICIANS HEALTH SERVICES	111,710	136,921	147,221	8	32
PRUDENTIAL HEALTH CARE PLAN	0	3,905	5,177	33	NA
SUBURAN HEALTH PLAN	1,618	2,735	2,767	1	71
U.S. HEALTHCARE	5,441	29,442	30,594	4	462
TOTALS	510,159	671,492	863,079	29%	69%

Section IV: Controlling Medicaid Expenditures

Connecticut clearly has one of the most expensive Medicaid programs in the nation. The program will continue to have a significant impact on the state's budget unless costs are contained. Basically, there are four ways to reduce program costs, each of which would have a significant impact on total expenditures. The four components of the medicaid cost equation are: 1) client eligibility; 2) health benefits; 3) fees; and 4) services.

Under a fee-for-service system, the department historically attempted to contain Medicaid costs by reimbursing providers at low rates. By moving Medicaid clients into managed care, the department will try to contain costs by reducing expensive care that is unnecessary, improving patient education, coordinating services, and controlling utilization. Under a prepaid payment system and through utilization management, private sector health plans will seek to hold providers accountable for the economic consequences of inappropriate use of services. The Department of Social Service will be responsible for ensuring that clients are not underserved and are receiving quality health care.

Client Eligibility

One way to reduce medicaid costs would be to reduce the number of beneficiaries eligible for services by establishing more restrictive eligibility criteria. Since Medicaid is an entitlement program, the number of eligible recipients is determined by state and federal criteria and is based upon household income and assets. Federal law mandates Medicaid coverage for certain groups of recipients and allows states the option of extending coverage to other categories of people. States would have to significantly restrict eligibility within this latter group, often among the most medically needy, in order to have any meaningful impact on Medicaid expenditures.

During the 1991-94 period, the number of clients eligible for the Medicaid program in Connecticut rose by 28 percent. The largest increase in clients occurred in the AFDC and AFDC-related populations which experienced a 31 percent growth rate. Table IV-1 shows the number of eligibles for each category of beneficiaries.

Table IV-1. Medicaid Eligible Clients: 1991 compared to 1994.

	FY 91	FY 94	Percent Change
AFDC & Related Groups	160,744	210,582	31%
Aged, Blind, & Disabled	42,326	53,476	26%
Long-term Care	19,670	22,135	13%
Total	222,740	286,193	28%

Source: Department of Social Services.

Given that the increases in the number of clients (28 percent) is less than the overall increase in total Medicaid expenditures (35 percent), a portion of the cost increase must be attributable to either increases in prices and fees for service or changes in the volume of services. Most likely, additional growth is due to a combination of price and volume increase.

Limiting eligibility for the Medicaid program would have serious implications. This approach would be contrary to the direction the state has moved over the past five years. As noted earlier, Connecticut has one of the lowest overall rates of uninsured and the lowest rate of uninsured children. The state also has one of the best rates of access to primary care services. This has been achieved by expanding Medicaid coverage to certain groups of low-income families.

Recent health care reform initiatives in other states have sought to expand insurance coverage to low-income groups and the working poor. While Connecticut has yet to expand coverage to the working poor (with the exception of the Healthy Steps pilot program in New Haven), doing so is one of the key features of any welfare reform program. Losing health insurance as a result of leaving welfare for work is a substantial deterrent to seeking employment. Reforming the welfare system by moving people into the labor force requires that individuals continue to maintain health insurance. States have sought an expansion of their Medicaid program to overcome this obstacle. Therefore, restricting eligibility is a limited policy option for reducing expenditures.

Scope of Health Benefits

The second component contributing to Medicaid costs is the package of health benefits. States are required to provide certain services such as inpatient hospitalization and have discretion in providing other services, such as dental and vision care. Decisions by the state to provide recipients with services that are optional under federal law, also increase the costs of the Medicaid program. As noted earlier, Connecticut has one of the richest benefit packages for Medicaid recipients. The state provides clients with almost every optional health service allowed by federal law. Reducing the benefits provided would be one way to reduce program expenditures.

Table IV-2 outlines the various categories of services for the 1991-1994 period. In particular, several areas show substantial expenditure increases. Reimbursement for individual providers, both for physician and dental services, grew at the rate of 76 and 103 percent respectively. Another major growth area has been clinic and laboratory services expanding at the rate of 73 percent. Hospital services, both inpatient and outpatient, which represent 49 percent of total costs, increased 46 percent. These high growth areas are reimbursed on a fee-for-service basis with little incentive to control utilization.

Some of the increase in these categories can be attributed to an increase in fees. For instance, fees for children's dental services were raised to 90 percent of the prevailing charges during this period to encourage provider participation, and fees for pediatric services were also

increased. However with minimal control over utilization of services by clients, it is difficult to determine the underlying factors responsible for the rapid rise in expenditures for these areas. Most other fees have not been raised substantially, therefore some of the increase must be attributable to an increase in the volume of services provided.

Reducing benefit levels. The Department of Social Services proposed as one of its budget reduction options for the FY 93-95 biennium the elimination of optional services for an estimated savings of $75.5 million in FY 94 and $100 million in FY 95. The department suggested elimination of the following services: pharmacy, certain types of clinics, dental, durable medical equipment, vision, and coverage for particular practitioners. While these services are considered optional under federal law, Connecticut has historically included them as part of the benefit package.

Table IV-2. Medicaid Expenditures by Service: FY 1991 compared to FY 1994.

Type of Service	FY 1991	FY 1994	'91-'94: % Change	1994: % of Total
Inpatient	$168,325,400	$245,128,322	45.63%	33.10%
Outpatient	79,043,528	115,465,960	46.08%	15.59%
Physicians & Other Providers	48,689,157	85,594,987	75.80%	11.56%
Pharmacy	65,235,991	94,554,709	44.94%	12.77%
Home health care	55,803,876	59,448,933	6.53%	8.03%
Clinic & Laboratory	22,983,530	39,650,210	72.52%	5.35%
Transportation	17,024,287	26,425,337	55.22%	3.57%
Durable medical equipment	16,300,129	24,673,658	51.37%	3.33%
Community service waivers	23,476,838	21,984,094	-6.36%	2.97%
Dental	10,006,660	20,322,090	103.09%	2.74%
Vision	3,676,829	4,977,951	35.39%	0.67%
Other services	0	2,214,283	NA	0.30%
Town assistance	1,457,635	139,491	-90.43%	0.02%
Total	$512,023,860	$740,580,025	44.64%	100.00%

Source: Department of Social Services: Medical Assistance Annual Expenditure Report - 1991 & 1994.

Before eliminating these services it is important to understand the extent to which they are used. Although all Medicaid recipients are eligible to receive optional health services,

program review committee staff obtained information on only one of the Medicaid groups using these services. Based upon an AFDC and related groups' FY 93 data set, there is extensive use of these optional services. There were over 1 million claims for pharmacy services provided to over 250,000 individuals. Dental services were delivered to more than 96,000 patients accounting for 192,000 visits to 800 dentists or clinics. Medical clinics served 48,000 clients which would likely be shifted to hospital outpatient facilities if the service was eliminated. In addition, 10,000 patients received some form of medical supplies. Finally, while eliminating vision services may seem appropriate in the light of the fact that few other state residents receive such a health benefit, it would save the program only $5 million. Furthermore, the number of claims submitted and individuals using these services would increase if information on the aged, blind, and disabled recipients was available.

Besides the number of individuals served, reducing health benefits would have short-term savings that could lead to long-term costs. For instance, eliminating prescription drugs would make it very difficult for many physicians to provide medical treatment for patients. Inpatient hospital costs, which represent the most expensive category of service, would probably increase as a result of not adequately treating patients at the initial stages of illness. Even dental services can prevent more expensive treatments that occur when care is neglected.

Medicaid Fees

The third component affecting Medicaid expenditures is the price charged for services rendered, which heavily impacts total program costs. As medical fees increase, total expenditures will also increase without a corresponding decrease in the volume of services used. The state has attempted to contain Medicaid expenditures by not raising fees for various services, but this approach has failed because there are not adequate controls on service utilization.

Provider fees are established by the Department of Social Services for all categories of services from outpatient clinics to transportation. As discussed previously, some fees have not changed for five years while others are updated more frequently. This has resulted in several legal challenges by various groups. For instance, an agreement with the Hartford Legal Aid Society forced the department to increase fees for family medical, pediatric, and obstetrical services. In another important case, the department's method for paying inpatient hospital costs is being challenged in federal court.

The main problem with the department's reimbursement system is that fees are not necessarily based upon the resources used, the severity of illness, or the medical treatment provided. Fees are more dependant on where services are received or, in the case of inpatient hospital charges, fees are capped at an arbitrary level for each patient.

Negotiating fees is one of the key cost containment provisions undertaken by managed care organizations. Individual managed care health plans have a much greater incentive to set prices based on competition in the marketplace for health services. As the Medicaid population is moved into managed care arrangements, it becomes the responsibility of private health plans

to contract with providers for the best possible rates. Under the current fee-for-service model, the department establishes fees based upon historical trends which may no longer represent current economic conditions.

Utilization of Health Services

Finally, the last component affecting program cost is the volume of services used by Medicaid clients. Utilization of services represents a major factor in the health care cost equation. To date, the department has done little to control utilization. While prior authorization for some services is required, the department is not particularly aggressive in using this approach. In fact, given the volume of claims in the Medicaid system, the limited staff resources, and the lack of health outcome data, the department has had almost no impact in controlling utilization. However, this needs to be the focus of any cost containment effort since it can have the most dramatic impact on reducing expenditures.

Table IV-3. Analysis of Medicaid Health Services for AFDC & Related Groups for 1992-93.

Classification	Total Expenditures	Total Patients Served	Total Claims Paid	Average Cost Per Patient	Average Cost Per Claim
Medical Supplies	$ 4,021,101	10,071	23,565	$ 399.28	$ 170.64
Transportation	6,208,667	44,512	154,957	139.48	40.07
Medical Clinic	9,401,420	48,016	143,477	195.80	65.53
Dental Services	10,025,229	96,583	192,294	103.80	52.13
Specialists	13,918,334	149,165	290,160	93.31	47.97
Other Health Services	16,243,793	119,698	261,465	135.71	62.13
Mental Health	19,429,111	17,913	93,889	1,084.64	206.94
Pharmacy	20,220,486	258,414	1,046,228	78.25	19.33
Primary Care	24,708,343	125,811	373,772	196.39	66.11
Outpatient	60,982,032	175,347	569,076	347.78	107.16
Inpatient	$108,804,310	31,312	37,006	$3,474.84	$2,940.18

Table IV-3 illustrates the impact utilization has on overall expenditures. In the table, volume is measured by claims paid for each of the major service categories. Based upon a data set limited to AFDC and AFDC-related groups, there were nearly 3.2 million claims paid for services rendered. It is this volume of services over which the state has the least amount of control. Medicaid clients have the freedom to choose who they want to see and how often they use a variety of medical services. While some services require prior approval, there is no active

case management of clients to indicate if the services received are the most appropriate, coordinated with other health services, and medically necessary.

Table IV-4 shows the reduction in costs that would result if a 10 percent reduction in the number of claims for each area of service (computed by multiplying the total claims by the average cost per claim) were realized. While the table is only illustrative and represents a simplistic cost reduction scenario, it does present a picture of what could occur if medical care is managed more directly rather than simply having claims reimbursed by a third-party payer.

Table IV-4. Analysis of Medicaid Health Services for AFDC & Related Groups for 1992-93.

Classification	Total Expenditures	Total Claims Paid	10 Percent Reduction in Claims	Resulting Cost Reduction	Potential Savings
Medical Supplies	$ 4,021,101	23,565	21,208	$ 3,619,018	$ 402,082
Transportation	6,208,667	154,957	139,461	5,588,214	620,452
Medical Clinic	9,401,420	143,477	129,129	8,461,843	939,576
Dental Services	10,025,229	192,294	173,064	9,021,857	1,003,371
Specialists	13,918,334	290,160	261,144	12,527,077	1,391,256
Other Health Services	16,243,793	261,465	235,318	14,620,338	1,623,454
Mental Health	19,429,111	93,889	84,500	17,486,450	1,942,660
Pharmacy	20,220,486	1,046,228	941,605	18,201,228	2,019,257
Primary Care	24,708,343	373,772	336,394	22,239,060	2,469,282
Outpatient	60,982,032	569,076	512,168	54,883,965	6,098,066
Inpatient	$108,804,310	37,006	33,305	$ 97,923,870	$10,880,439
Total	$293,962,826	3,185,889	2,867,300	$264,572,925	$29,389,900

Source: Department of Social Services Data Base for AFDC & Related Groups.

Section V: Planning for Medicaid Managed Care

The Medicaid program, as originally adopted by Congress, is widely recognized as inappropriately designed for the cost effective delivery of quality health care services. In fact, the lack of incentives under a fee-for-service model exacerbates costs and has led the private sector to move away from this type of delivery system. Although the private health care market has reacted to the escalation of health care costs by adopting a managed care approach, Medicaid, as a health program, has been slower to respond.

Like Connecticut, many states have been faced with rapidly rising Medicaid expenditures due to increases in clients, expansion of health benefits, medical price inflation, and increases in the volume of services. While costs have escalated, states have been unable to quickly implement changes in program requirements that lead to lower costs without first receiving a federal waiver.

The Medicaid program has operated primarily as a fee-for-service freedom-of-choice health insurance plan. Clients may obtain health services from any licensed institution, agency, pharmacy, person, or organization that agrees to accept the fees established by the Department of Social Services. The department reimburses providers for services rendered with little or no management of care provided to clients. Rather, the focus of the department has been on processing and paying claims, along with conducting a number of administrative and quality assurance functions needed to operate the program. The program has operated in this fashion since the 1960s.

To reverse this trend, states have looked to "managed care arrangements and systems" developed by the private sector to provide health services in a more cost efficient manner. Adoption of managed care for Medicaid recipients is appealing to states because these systems can better respond to problems endemic to the program such as poor provider participation and unnecessary or inappropriate utilization of services. Managed care is viewed as a way to link recipients with primary care providers, and as a result, control over-utilization of services. Most states have sought waivers from the federal government to allow managed care organizations to administer the Medicaid health services on a pre-paid basis. Since 1981, states have moved nearly 5 million medicaid clients into some form of managed health care, a 20-fold increase.

Connecticut's Medicaid Managed Care Program

Connecticut's Medicaid program is about to undergo a major transition. Connecticut has lagged behind almost all other states in adopting a managed care program for its Medicaid recipients. Although the department intends to submit a request for a federal waiver under section 1915(b) of the Social Security Act (see Appendix A) in January 1995 which will allow it to operate a Medicaid managed care program, there have been several delays in meeting their established time-table. Scheduled to begin enrolling clients on July 1, 1995, the program will be changed from a fee-for-service freedom-of-choice model to pre-paid case-managed health plans largely administered by private companies.

To advise and monitor the department in planning and implementing managed care the legislature adopted Public Act 94-5 (May Special Session), which created a 26-member council. The council is required to make recommendations in several program areas and report back to the General Assembly.

A draft of the waiver application, obtained by the program review committee, provides a description of how the program will be operated. Described below are the key elements of the program design that will allow transition of Medicaid recipients into managed care health plans.

Targeted population. The department has identified the AFDC and AFDC-related populations as the groups to enroll in managed care health plans. Table V-1 provides a breakdown of the number of individuals within each targeted group and total expenditures for each group in FY 93. The table also shows the average expenditure per eligible per month.

Table V-1. Distribution of Persons by Eligibility Category - FY 93.

Category	Total Expenditure	Average Eligible	Average Cost Per Eligible Per Month
AFDC	$200,011,372	150,650	$110.64
Ribicoff Children	21,329,463	10,548	$168.51
Children 18-21 Caretakers	30,744,531	15,717	$163.02
Other	$30,063,783	11,770	$212,85
All Target Groups	$282,149,149	188,685	$124.61

Source: Department of Social Services.

The department plans to divide the state into at least two regions for the purposes of enrollment and enrollment will be mandatory as long as two health plan choices are available in an area. There are several reasons to require mandatory enrollment in health plans. First, this ensures a full transition away from a fee-for-service delivery system. In addition, it guarantees providers a significant volume of patients, which makes health plans more eager to participate in the program. Finally, risk selection is minimized since everyone is required to join a health plan.

States usually require the AFDC populations to join managed health plans first, because it is believed that they benefit more than other populations from the types of preventive services emphasized under managed care. Under these plans, inappropriate or overuse of expensive services will be avoided and cost effective preventive services provided. In addition, AFDC and

AFDC-related groups are fairly young and therefore, resemble populations already served by commercial HMOs.

The department has excluded certain medicaid recipients from the managed care program. These groups include institutionalized persons, adults eligible for SSI, and most medically needy eligibles. Although these are the most costly persons in terms of resources consumed, they also are the most medically-challenging and therefore, the most difficult to move into managed care.

The enrollment process. The department will begin enrolling individuals on July 1, 1995. Full enrollment is expected to take 12 months, since the program will be phased-in -- using a person's date of eligibility recertification as their expected enrollment date. Medicaid recipients will have a 30-day period after they initially select a health plan to disenroll and switch to another plan. After that period however, disenrollment without cause will be restricted for a 5-month period. This "lock-in" provision provides more stability for health plans that need predictability in expenditures to better manage their risk.

The department will contract with a private entity to act as an "enrollment broker" who will be responsible for supplying plan information to recipients and enrolling clients in the various health plans available. The broker's role will also include explaining enrollment choice, assisting the recipient in provider selection, and discussing procedures for changing plans, and disenrolling. Plans will not be allowed to market directly to recipients, but may be allowed to give presentations in a forum designed by the department. In addition, the broker will have a variety of other functions including:

- the creation of educational materials;
- informational presentations to recipients and providers;
- providing training to local DSS offices; and
- maintaining toll-free hotlines for recipients and providers;

Designated provider. The department will select a "designated provider" whose health plan will be the default choice for those clients who fail to enroll in a plan. The percentage of clients that must be assigned to the designated provider plan varies depending on how well the enrollment process is designed, with some states experiencing only 5 to 10 percent of their eligible populations being assigned to a default plan. If more than one designated provider is chosen for a region, default enrollment will be proportionately allocated. Only fully capitated plans will be eligible to be awarded the three-year contract.

Access to services. All health plan enrollees will have round-the-clock access to their chosen primary care physician (PCP). The provider networks are expected to include most of the existing Medicaid primary care providers, as well as new providers. Plans will be required to submit a Medicaid-specific access enhancement program to the department, as well as the following outcome measures:

- the number and timing of prenatal visits with each pregnancy;

- the number of patients who received no services;
- immunization statistics;
- EPSDT compliance statistics; and
- other relevant health statistics.

Health plan selection process. The Department of Social Services was granted the authority to contract with pre-paid health plans for Medicaid services by Public Act 94-5 of the 1994 May special Session. Three types of health plans are eligible to participate in the program.

- state licensed HMOs that must provide comprehensive Medicaid benefit package;

- fully capitated[1] prepaid health plans owned by a consortium of federally qualified community health centers and other state-funded community-based health service providers who must offer the same benefit package as HMOs; and

- partially capitated health plans (PCHP) that cannot be HMOs and are not at risk for inpatient hospital services but would receive a bonus for staying within prearranged caps. PCHPs will not be eligible to serve as a designated provider unless fully capitated health plans were not available in a region. A PCHP must be owned by an health care provider or network of providers such as hospitals or medical group practices.

Non-HMO prepaid health plans and PCHPs do not currently exist in Connecticut. However, in order for any health plan to participate several criteria must be met. First, the plan must be adequately capitalized and have the ability to manage financial risk. In addition, the plan needs to be able to deliver or arrange to deliver all services reimbursable under the contract. The plan must also have the ability to provide emergency services on 24-hour, seven-day a week basis. The plan should also provide for a system for coordination of care, operate an internal quality assurance program, demonstrate the ability to comply with EPSDT targets, and provide ongoing member education and information.

Plans will be paid on a capitated basis. The base capitation will be a statewide rate with adjustments for geographic region, age, and sex. The capitated rate will be set at approximately 95 percent of the estimated fee-for-service costs with the exception of the designated provider, which will be established through a competitive bid process.

Quality Assurance

Under federal law, the state is required to have an annual, independent, external review of the quality of services delivered under the program. The department will contract with a

---

[1] Capitation is a set amount of money calculated on a per member per month (PMPM) basis.

quality assurance organization to conduct site visits, perform clinical chart audits, and audit compliance with the plan's procedures. In addition, the contractor will review client and provider enrollment and use patterns, as well as analyze various health access and outcome measures. The contractor will report to the department annually with its findings and perform ad hoc reviews at the department's request. Satisfaction surveys will be sent to all recipients and responses will be evaluated by the department.

Section VI: Findings and Recommendations

Introduction

The state of Connecticut will undergo a significant policy change in how health services are paid for and delivered to many of its Medicaid recipients. This change will have important implications for the health care delivery system as large numbers of recipients are enrolled in managed care health plans offered in the private insurance market. Many states are further along then Connecticut with inclusion of persons with disabilities and elderly into managed care delivery systems. Connecticut needs to firmly set a public policy direction by moving all health services, with the exception of long-term care, into managed care arrangements if it is to control medicaid expenditures.

Connecticut is one of the last states to enroll its Medicaid population into managed care health plans. In 1992, 35 states and the District of Columbia had managed care programs for Medicaid recipients, accounting for about 12 percent of the national Medicaid population. Since then, 13 other states have decided to move into managed care programs. As states wrestle with spiraling program costs and limited state budgets, managed care is viewed as a way in which to slow the growth rate of the program, as well as improve health services. States have implemented a variety of managed care models, each program designed to meet the needs of its own population.

Under a fee-for-service model, states, like Connecticut, find it difficult to perform oversight on the volume of services used by clients and are unable to selectively contract with providers to obtain the most cost-effective services. A change in the way Medicaid services are financed and delivered is required if the state is going to control and improve the predictability of expenditure increases. Managed care organizations are designed to combine the delivery of health services with the financial management of medical care to better contain costs and improve the quality of service.

While there are a variety of managed care organizations operating in Connecticut,[2] those licensed as health maintenance organizations provide pre-paid health plans covering medical benefits for employees. HMOs establish networks of providers through negotiated contracts and attempt to control utilization of services using various management techniques. Essentially, managed care organizations are required to operate within a health care budget based on the premiums charged for enrollees, and seek to control price by negotiating fees with providers and control the volume of services through utilization review methods. It is through these controls, and the budget constraint, that managed care organizations contain overall health care expenditures.

---

[2] For more information see the Legislative Program Review Committee's report on Health Care Cost Containment in Connecticut, February 1994, Chapter II.

It is imperative Connecticut move its Medicaid population into managed care arrangements. Although the AFDC and AFDC-related populations, which represent about 73 percent of Medicaid clients, will be moved into pre-paid health plans, these groups account for only 23 percent of Medicaid expenditures. The program review committee believes the department's efforts should be supported and expanded to other Medicaid recipients. Persons who are aged, disabled, or blind represent 25 percent of the total cost and 19 percent of the clients. The remaining expenditures, over 50 percent, are attributable to long-term care. The state needs to move all health services, with the exception of long-term care, into managed care arrangements if it is to control medicaid expenditures. Furthermore, long-term care needs to be closely examined to determine if there are alternative models for providing services that can better control costs.

Client enrollment into managed care health plans is scheduled to begin on July 1, 1995, however this deadline is in serious jeopardy. The Department of Social Services has yet to submit the necessary federal waiver, as of this writing, and cannot proceed without approval. Other deadlines, such as final "request for application" proposals for pre-paid health plans have not been met. The program review committee found a number of deficiencies in the program administration and design that need to be corrected to insure success of Connecticut's managed care enterprise. Those findings and recommendations will follow. However, the Legislative Program Review Committee in terms of an over-all state policy recommends that:

> **The commissioner of the Department of Social Services shall be required to enroll the entire Medicaid population, with the exception of those clients receiving long-term care assistance, into managed care pre-paid health plans. It is further recommended that The Department of Social Services begin enrolling Medicaid clients by July 1, 1995, in compliance with federal laws and regulations, and that all health services for Medicaid clients, with the exception of long-term care, be provided through pre-paid health plans by December 31, 1997.**

If the escalation in Medicaid expenditures is to be slowed, Connecticut needs to seriously redesign how health services are delivered and paid for. Instead of simply being a payer of bills it must use its strength to purchase competitive health plans and provide the clients it serves with high-quality, cost-effective medical services. Given the fact it insures over 200,000 individuals, the state has the buying power to create a competitive market for Medicaid health services.

Program Administration and Design

The Department of Social Services must redefine its role and accept several new responsibilities. The following findings and recommendations identify major administrative deficiencies that need to be addressed before moving to a managed care program. The recommendations are aimed at enhancing the internal capacity of the department to support the successful transition to managed care and ensure appropriate monitoring once the program is operational.

Department Reorganization

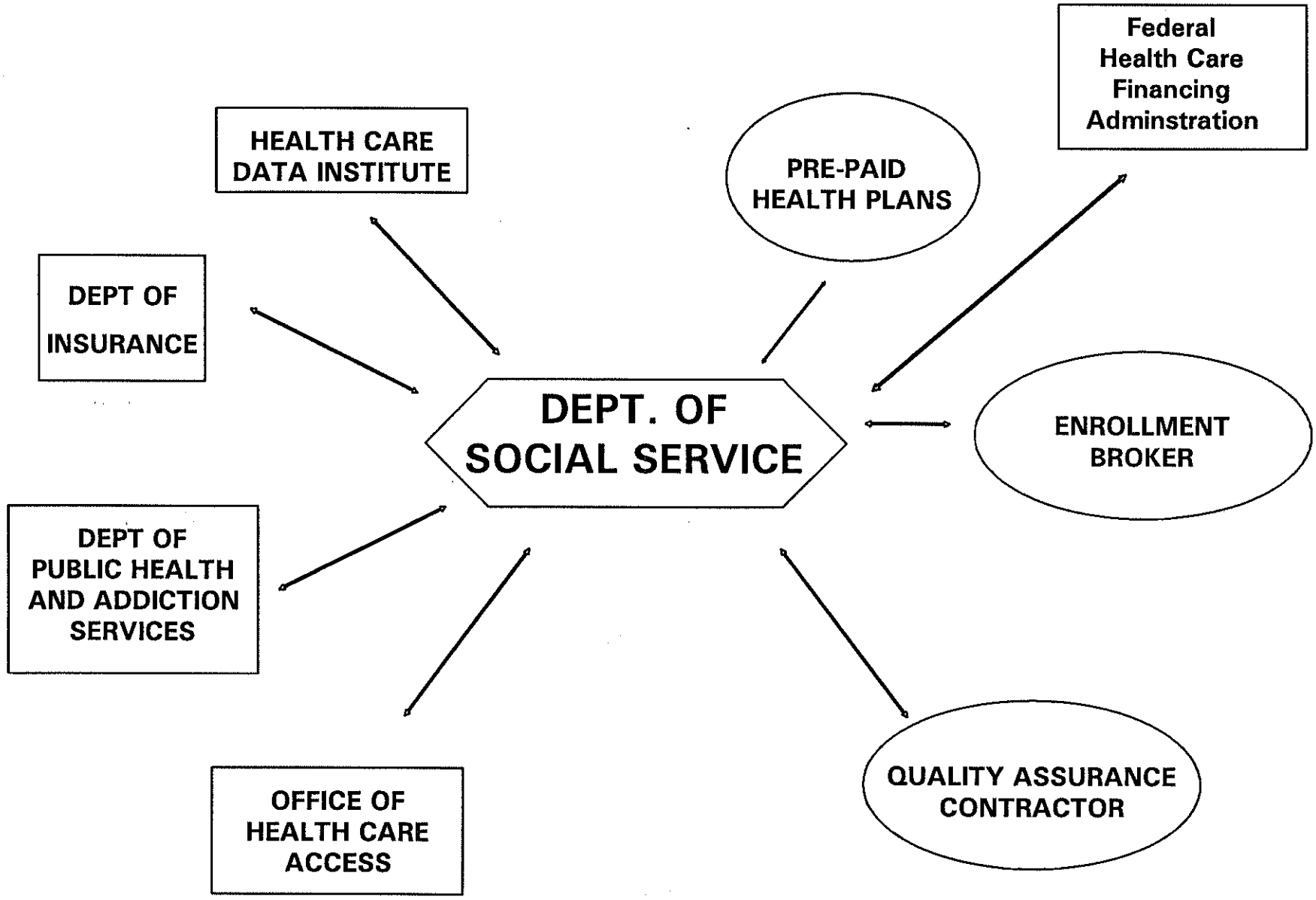
Since the 1960s the administration of the Medicaid program by the Department of Social Services has primarily focused on setting provider rates, evaluating claims information, and verifying eligibility. With the implementation of a managed care program scheduled to begin next fiscal year, the department must undergo a major transformation in its approach to the delivery and financing of health services for Medicaid recipients. The department's role will primarily be one of negotiator and overseer in a privately delivered but publicly funded health care system. Analysis and evaluation of the quality and cost of services and identification of deficiencies will be important responsibilities of the department.

Under the managed care program, the Department of Social Services will greatly expand its operations as a major purchaser of client health services offered in the private insurance market rather than merely a payer of claims. Much of the operation of the managed care program will be conducted by private organizations; from the enrollment process and the delivery of services, to major portions of the quality assurance review. In many ways, the department will be analogous to a health purchasing cooperative for the Medicaid population -- negotiating with health plans based on cost and quality and providing members with comparison information about the plans offered.

Figure VI-1 shows the number of entities with which the department will have to interact under a managed care system. The Department of Insurance will examine the financial solvency of health plans and notify the Department of Social Services of its findings. The Department of Public Health and Addiction Services will provide information on its funded programs and the types of base-line data collected. The Health Care Data Institute, the future repository of all health care data in the state, can use Medicaid data as a model for the design of other health care databases. In addition to these state agencies, there will be several private entities under contract to the department. Several types of health plans, an enrollment broker, and an independent quality assurance contractor, will all have to provide information to the department. For DSS to evaluate the information gathered from the various entities and use it to improve the program, an appropriate organizational structure needs to be in place.

The current structure of the department is unable to support the managed care initiative. A review of the organization of the Medicaid Bureau (as shown previously in Figure II-1, p. 12) by the program review committee found minimal staff resources dedicated to perform the oversight functions that will be necessary to competently operate the new program. This raises serious doubts about the department's commitment to implementing managed care. To date, several department-established timelines have already been missed, yet more staff have not been assigned to the effort. This is particularly troublesome, given that over 188,685 Medicaid recipients will be affected by the sweeping change. Furthermore, administration of a managed care program is so unlike that of a fee-for-service program that commitment of staff with special expertise in managed care is necessary early on in the program.

Figure VI-1. Medicaid Managed Care Environment



To assist in the development of the program a 14-month, $629,713 consultant contract was awarded to Lewin-VHI, Inc. Because it lacks adequate staff and has no internal capability to generate information, the department has relied heavily on Lewin-VHI, Inc. for development of the program design. This has resulted in the consultant having significant influence in many of the policy decisions concerning Connecticut's Medicaid managed care initiative.

The success of the managed care program depends on the ability of the Department of Social Services to create an internal capacity to evaluate the health care market and the quality of care its clients are receiving. From this, the department can develop better policies aimed at continuous improvement of program operations.

The Legislative Program Review Committee recommends the Department of Social Services establish a Managed Care Division within the Health Care Financing Bureau. The division will be solely responsible for administration of the managed care program and be involved in the following functions:

- **evaluating and contracting with prepaid health plans including negotiation and establishment of capitated rates;**
- **assessing quality assurance information compiled by the federally required independent quality assurance contractor;**
- **monitoring contractual compliance;**
- **evaluating enrollment broker performance;**
- **assisting the Health Care Data Institute in establishment of a Medicaid data base; and**
- **providing assistance to the Department of Insurance for the regulation of managed care health plans.**

The division shall be responsible for all aspects of the managed care program. The Department of Social Services shall develop a plan for enrolling the entire Medicaid population, with the exception of long-term care recipients, into prepaid health plans and report to the legislature by February 1, 1996.

Placing the responsibility for the managed care program in a separate unit emphasizes the importance of the program within the Department of Social Services. In order for the program to be successful, department leaders need to show that movement into managed health care is a priority. This can be accomplished through establishment of a single managed care unit with six to eight staff drawn from other areas of the Health Care Bureau.

In addition, a separate managed care unit will allow for more rational oversight of the program instead of splitting responsibility among different units within the department, each with varying priorities and expertise in the managed care area. The proposed organization fixes accountability within one unit instead of across department lines. As problems occur within the new program design, responsibility and authority to make programmatic decisions will be quickly and clearly defined under the new structure.

Although a significant part of the Medicaid population is targeted to enter managed care, aged, blind, and disabled Medicaid recipients will remain under a fee-for-service system. However, as the department develops more expertise in administrating the program, and as the private sector moves farther away from indemnity insurance, these Medicaid recipients will also need to be enrolled into managed care health plans. When this occurs, the department can reallocate staff to the Managed Care Division.

Quality Assurance

One of the department's most important functions in managing the new delivery system is a rigorous quality assurance program. Since most of the program operations will be performed by private contractors, including health delivery, plan enrollment, and many of the quality assurance functions, the department needs to have clearly defined standards in place to ensure clients receive necessary services and plans are fulfilling their contractual obligations. Quality assurance information produced should be used by the department as a management tool to identify and resolve problems.

A primary concern of a Medicaid managed care delivery system is that recipients not be underserved as health plans focus on cost containment rather than on quality care. However, there can be more accountability in a managed care system since coordinated care and oversight are its cornerstones. Under Medicaid managed care a variety of outcome data can be routinely collected and monitored (such as enrollment and disenrollment processes; grievance outcomes; utilization rates; and patient satisfaction surveys). Conversely, under the current fee-for-service design, there is almost no systematic review of client services and little oversight by state Medicaid agencies. The lack of oversight leaves clients particularly vulnerable since there is little evaluation being performed on the quality of services delivered by providers.

Federal requirements. To obtain a federal waiver to operate a Medicaid managed care program, a state must meet four federal requirements concerning quality assurance activities. First, federal law requires all managed care organizations contracting with state Medicaid programs, under capitation or other risk payment arrangements, to have a written internal quality assurance plan (QAP). In addition, HMOs must have a grievance procedure approved by the state medicaid agency. Federal law also requires an annual independent external quality review for HMOs. Three types of entities are permitted to perform the review:

- Peer Review Organizations (PRO);
- PRO-like entities; or
- accrediting organizations.

This review examines the structural capacity of plans (administrative procedures, internal quality assurance process, credentialing, medical record reviews, and review of clinic sites). The fourth federal requirement calls for periodic medical audits of prepaid health plans that are not HMOs. This review is similar to the external review requirement for HMOs.

Federal requirements address the structure and process of quality assurance systems, but are not designed to measure health outcomes. Recognizing this, the Health Care Financing Administration (HCFA), in conjunction with the Kaiser Family Foundation, began its Quality Assurance Reform Initiative (QARI) in 1991 to develop methods and standards for monitoring the quality of care provided to recipients under capitated managed care arrangements. A uniform set of guidelines for managed care organizations was developed with input from other states, providers, and representatives of the managed care industry. Three states have been selected as demonstration project sites to test the guidelines.

The QARI guidelines provide assistance in defining the responsibilities of the various participants under Medicaid managed care. Health plans would have several responsibilities for monitoring and evaluating the care delivered through its network of contracted providers. Specifically, the plan should demonstrate it has:

- a credentialing process with minimum qualification criteria for its practitioners;
- the ability to detect and correct inappropriate care provided by providers;
- a written grievance process for enrollees;
- written material available to enrollees explaining rights and responsibilities; and
- systems to submit required data to the state medicaid agency.

Under the guidelines, the state's role in quality assurance is monitoring managed care plans to hold them accountable for all contract provisions. This is accomplished by reviewing plan information and auditing it for accuracy. Additional quality assurance activities can include conducting patient satisfaction surveys, assessing enrollment and disenrollment levels and determining reasons for fluctuations, and evaluating enrollee grievance information.

Connecticut's plan. The three primary elements of a quality assurance system are determining the standards of quality; monitoring those standards; and enforcing them. In many ways, the success of a managed care program hinges on how well the state's quality assurance system functions.

The program review committee found the department ill-prepared to implement a solid quality assurance system. As emphasized in the previous recommendation, without the organizational structure, internal capacity, and expertise in the area of managed care, it will be difficult to operate a quality assurance program that will produce worthwhile information. In its draft federal waiver application, Connecticut incorporated the four federal requirements noted above, as well as the QARI guidelines into the description of its quality assurance. At the time of this report, little attention had been given to quality assurance because the department's efforts have been concentrated on development of request for applications for health plans and the enrollment broker.

The Legislative Program Review Committee recommends a quality assurance unit be established within the Managed Care Division. The unit will be responsible for identification of quality assurance problems and notifying the appropriate entity for resolution. The unit shall develop standards that establish, in advance, expected performance levels for health plans and for the enrollment broker. Performance measures shall be established for four areas -- quality, enrollee access and satisfaction, utilization, and cost.

The Managed Care Division shall develop a system to compare performance levels among health plans and produce a "report card" on each plan providing services. The report card shall be based on the four performance areas established by the department and be published annually.

The effectiveness of any quality of care standards greatly depend on the extent to which they are enforced by the state agency responsible for oversight. The department has the responsibility to set standards and monitor and evaluate the organized systems of care through which providers deliver services. The state should have procedures for monitoring adherence to standards, as well as the actual quality of care delivered. The program review committee found the department has not yet addressed these issues, nor what its responsibility and authority will be in terms of resolving quality assurance problems.

Medicaid Data Requirements

The Department of Social Services will be required to evaluate the impact managed health care has on its clients. To do so, the department needs to create base-line data from which to measure future changes. Moving medicaid clients into pre-paid managed care health plans will result in a major operational transformation of the program. To properly evaluate the impact on clients, adequate data on Medicaid utilization before and after the changes occur will be necessary.

The department has relied upon its consultant, Lewin-VHI, Inc., to create a Medicaid data base that merges client eligibility information with claims data. This data base was primarily used to establish capitation rates for health plans and provide information to the public on the Medicaid delivery system. In the future, health plans contracting with DSS will be required to submit data on each plan's operation and service utilization.

It is widely recognized that the inadequacy of data has hampered health care policy formulation. The program review committee, in its 1993 study of health care costs, found information on both the financing and delivery of health care severely lacking. Without detailed information, it is impossible to assess and monitor the state's health care delivery system.

Inadequate data have perpetuated a system in which health care choices are not made on the basis of quality or cost. As consumers have more health plan options available it is imperative that information exists that gives them the opportunity to knowledgeably select a plan

based on their needs. Data that integrate information on delivery and financing of health care allow them to compare health plans and make informed choices. Based on this finding, the committee recommended establishment of the Connecticut Health Care Data Institute which was created by the legislature in the 1994 session. The institute's mission is to create a state-wide data repository for a centralized cost and quality data system which can be used by both the public and private sectors.

The department lacks person-level data on health care utilization for Medicaid clients. However, under managed care it will obtain the necessary information to construct such a data base from information provided by contracting health plans. Then service utilization information by individual can be tracked over time. This type of data base will equip the department with the tools to adequately evaluate the impact of managed care on Medicaid clients. Such a data base, if made available to the marketplace, would encourage more plans to participate in Medicaid managed care by allowing the health plans to accurately assess the risk of insuring beneficiaries and providing services.

Data Requirements. The federal waiver application to be submitted by the department details the types of data that must be collected to competently monitor health plan capacity and oversee the managed care system. Several different categories of data have been identified by the department as essential to the project. These include:

- encounter data;
- financial data;
- medical chart audit;
- operational data;
- maternity and prenatal care data;
- credentialing files;
- reporting on the Early Periodic Screening Diagnosis and Treatment (EPSDT) program;
- enrollment rosters;
- client satisfaction surveys; and
- provider satisfaction surveys.

These data requirements are extensive and may also add substantially to the cost of health plans. Some health plans have complained that the data requirements imposed by the department are excessive and question whether anyone will actually make use of the information. Given that the department has very limited staff resources, the Legislative Program Review Committee also questions the department's ability to evaluate health plan data.

The Legislative Program Review Committee recommends the Department of Social Services provide the Connecticut Health Care Data Institute with a person-level Medicaid data base. The committee recommends this be accomplished by agreement between the department and the institute. It is further recommended there be established a Medicaid Data Committee to facilitate creation of the data base. The Medicaid Data Committee shall

be composed of the director of the DSS Medicaid Managed Care Division, the Director of the Connecticut Health Care Data Institute, a member of the advisory board of the institute, and representatives from the pre-paid health plans providing Medicaid services. The committee shall be charged with the responsibility for deciding the data elements needed to adequately evaluate health plans, specifications for uniformity, data security and client privacy protection, and the process for providing the data to the institute.

The Medicaid data base will serve as a model for the future collection of health care data by the institute. Establishing a data base that is accessible to all health plans and researchers will stimulate interest in serving the Medicaid population, contain costs, and improve the quality of the delivery system.

Medicaid Health Plans

The success of transitioning Connecticut's Medicaid population from a fee-for-service system to managed care will depend on the state's ability to contract with private health plans that are able to supply a wide array of health services on a pre-paid basis. The Department of Social Services is currently developing applications to solicit contracts from managed care health plans. The department will be required to review and accept plans that meet the needs of the state and it's Medicaid clients.

The Department of Social Services was granted the authority to contract with pre-paid health plans for Medicaid services by Public Act 94-5 of the 1994 May Special Session. This act allows the commissioner of social services to require recipients to receive medical care on a "prepayment or per capita basis, in accordance with federal law and regulations, if such prepayment is anticipated to result in lower medical assistance costs to the state."[3]

From the authority granted in the act, the department outlined the three types of pre-paid health plans that would be allowed to participate in the program:

- state licensed HMOs that provide comprehensive Medicaid benefit package;
- pre-paid health plans owned by a consortium of federally qualified community health centers, other state-funded community-based health service providers, or other consortia of providers established to provide Medicaid services; and
- partially capitated health plans (PCHP) owned by health care providers or network of providers such as hospitals or medical group practices. PCHPs

[3] Public Act 94-5, Section 27, May 1994 Session, Connecticut General Assembly.

are not at risk for inpatient hospital services, but could receive bonuses for staying within prearranged caps on inpatient costs.

The last two pre-paid health plans will require formal approval by the Department of Social Services before they are allowed to offer health insurance to Medicaid recipients. The department would be required to establish regulatory criteria and staff functions similar to those found within the Department of Insurance. This finding will be discussed in more detail later.

For any health plan to participate in the Medicaid managed care program several criteria must be met. Pre-paid health plans are insurance entities that must be able to collect premiums and pay medical losses. Therefore, plans must be adequately capitalized and have the ability to manage financial risk. This requires the regulator to diligently monitor the on-going financial integrity of the health plan to insure it is capable of meeting its obligations on a continual basis.

In addition, to be selected a plan must be able to deliver or arrange to deliver all Medicaid covered services. Each plan must establish a network of providers which is done through selective contracting. The plan must also have the ability to provide emergency services on 24-hour, seven-day-a-week basis. Plans should also provide for a system for coordination of care, operate an internal quality assurance program, demonstrate the ability to comply with the Early Periodic Screening Diagnosis and Treatment (EPSDT) targets, and provide ongoing member education and information.

Health plans will be paid by the state on a per-person (capitated) basis. This means that a health plan will receive a pre-determined dollar amount each month for each recipient enrolled. The capitated rate will be based upon current payment levels with adjustments for geographic region, age, and sex. Initially, the capitated rate will be set at approximately 95 percent of the estimated fee-for-service costs with the exception of plans that will competitively bid to become the default plan for those clients who fail to make a choice. These plans will be known as "designated providers."

The Need for Multiple Plans. The marketplace will most likely respond to the department's request for plan proposals in several ways. First, licensed HMOs will seek to participate in the new Medicaid managed care program. Second, groups of hospitals and community health centers have discussed forming corporate entities that will allow them to develop pre-paid health plans, deliver services, and cover Medicaid recipients.

The current structure of the Medicaid delivery system presents a difficulty for the department in moving to private managed care organizations. Connecticut's Medicaid population is largely served by two types of facilities; outpatient hospital clinics and community health centers. Based on the department's data for the 1993 AFDC population, 175,000 patients were seen at hospital outpatient clinics while medical clinics (community health centers) accounted for 48,000 patients. Another 125,800 patients were seen by primary care physicians operating in private or group practices. While primary care physicians have contractual relationships with many of the licensed HMOs, most of the community health centers and hospital outpatient clinics

that serve the poor do not. In fact, some HMOs have been reluctant to reimburse for services at these two locations.

Community health centers and outpatient clinics have historically provided services to a segment of the population that was underserved by private health care providers and have relied heavily on state and federal funding, mostly through Medicaid, to provide services. To ensure continued participate by these facilities, the department has provided them the opportunity to create their own pre-paid health plans. These plans would not be required to undergo examination by the Department of Insurance as required of HMOs. Instead, the Department of Social Services would establish criteria and review and approve such plans.

Commercial managed care in Connecticut is still in its early stages of development. From 1988 to 1993, HMO enrollment grew by only 32 percent, but then soared by 29 percent from 1993 to 1994. (Currently, 27 percent of the population is enrolled in HMOs.) Most of the HMOs operating in Connecticut have no experience in providing services to Medicaid recipients though some have limited Medicaid experience in other states. Two HMOs, one recently licensed and one seeking a license, have more significant experience operating in New York and New Jersey, but have only begun to develop their networks in the Connecticut.

Given that there is very little experience with providing pre-paid health services to Medicaid recipients in the state, it is necessary the department have flexibility in developing arrangements that best meet the needs of clients, providers, and insurers.

Regulatory capacity. The Department of Social Services will be taking on several regulatory functions for which is has no experience, trained staff, or organizational capacity. As noted earlier, the department is severely understaffed to adequately complete the transition from a fee-for-service system to pre-paid managed care health plans. Specifically, the department lacks the expertise to regulate health insurance entities.

While health maintenance organizations are clearly defined and detailed in statute (Chapter 698a, Part I, Health Care and Related Service Groups), pre-paid health plans and partially capitated plans referred to in P.A. 94-5 are not. By law, the department is called upon to establish criteria for approval of these plans.

To date, the department has relied upon its contractor, Lewin-VHI, Inc., to set-forth the application requirements. The draft application for partially capitated health plans (PCHP) distributed by the department lends insight into some of the new functions the agency must perform. PCHPs will be new organizations formed for the sole purpose of participating in the state's Medicaid managed care initiative.

With the exception of licensed HMOs, the department must review and approve the health plans in two distinct areas: 1) a plan's delivery system; and 2) a plan's financial management and ability to remain solvent. In terms of the delivery system, all provider contracts must be filed with DSS and must show evidence or descriptions of the following:

- malpractice insurance;
- access to providers within designated service areas;
- mechanisms for sharing risk with providers;
- contracted out services;
- credentialing system;
- network capacity, geographic coverage, and primary and specialist physician distribution for proposed service area;
- specialist referral processes including monitoring reports on referral visits;
- hospital networks, emergency care, and accessibility;
- pharmacy network;
- mental health and substance abuse network and services including contracts and referrals to child guidance clinics;
- EPSDT compliance and prenatal care requirements;
- membership enrollment processes, consumer information, complaint handling, and consumer satisfaction;
- utilization management system including authorization process and appropriateness of review procedures;
- claims processing and management information systems (including reports to monitor financial performance); and
- a quality assurance plan.

These areas focus primarily on the nature of the PCHPs' health services delivery systems; how services will be provided; who will be providing them; and what geographic areas will be served.

For financial management, the department must examine all documents related to the incorporation, ownership, governance, and staff of the plan. In addition, the financial and solvency criteria established by the Department of Social Services call for the following:

- the organization's capitalization plan including current balance sheet and audited financial statements;
- a sequestered capital reserve account equal to two months premiums or $250,000 which ever is greater with access to the account only with DSS approval;
- the plan's enrollment forecast and 3-year financial projections;
- all provider compensation and risk sharing arrangements;
- stop-loss insurance coverage documents; and
- the systems employed to track claims, structure capitation payments, and manage risk to insure solvency;

The department will also require health plans to submit audited and unaudited financial reports and create a computerized data base of all care provided to enrollees including claims and service encounter data.

Staff examination of the role of the Department of Insurance in regulating HMOs indicates that many of the responsibilities to be undertaken by the Department of Social Service are being performed within that agency. The Department of Insurance has well-developed systems for licensing and conducting on-going reviews of provider network adequacy and financial solvency of health plans. Regulating health plans would be a significant departure from the mission of the Department of Social Services. It would also require the department to create new organizational entities to carry-out these functions, in addition to hiring staff with insurance expertise. The Department of Insurance has recently gone through a significant expansion of staff resources to meet the financial examination requirements of the National Association of Insurance Commissioners and currently has the adequate capacity to license and examine new health plans seeking to do business in Connecticut.

The Legislative Program Review Committee recommends the Department of Social Services contract with the Department of Insurance for the approval and ongoing oversight of all pre-paid health plans providing Medicaid services. The committee further recommends the creation of a joint committee of members from each department for the purpose of developing and regulating Medicaid health plans. No pre-paid Medicaid health plan shall be allowed to operate without approval by the commissioner of insurance.

A contract between the Department of Social Services and the Department of Insurance will ensure health plans are not only appropriately regulated for financial solvency, but services are available and being provided. One of the functions of the Department of Social Services will be the continuous evaluation of services delivered to recipients under the various health plans offered. Because of this, the department can provide valuable assistance to the insurance department in reviewing the adequacy of a health plan's network. Thus, a cooperative effort by both agencies will ensure plans remain financially viable and delivery systems are sufficient.

Medicaid Rate-setting Systems

The department currently uses three separate rate-setting systems: one for inpatient hospital rates; another to set fee schedules for physician payments and ancillary services such as prescriptions, transportation, eye glasses, and laboratory tests; and one for nursing home rates. As the department moves to pre-paid health plans, it will become involved in a fourth rate-making system, the development of capitated (per-person) rates for Medicaid clients. Eventually, most of the department's clients will be covered by capitated health plans and its dependence upon the current fee system for hospitals and health services will be diminished. However, there will always be a need for a separate fee-for-service system as some clients will remain outside of pre-paid health plans. For instance, some clients become eligible for Medicaid after they have received health services; providers for those clients will be reimbursed on a fee basis.

Under federal medicaid law each state retains primary authority to develop provider payment methods and rates. States are able to establish the unit of payment for services and

typically pay per encounter such as an office visit or hospital stay. However, rates may vary based upon the length of the encounter.

In Connecticut, the Commissioner of Social Service is granted broad authority to establish "a uniform schedule to apply to practitioners of the healing arts and allied professions..." which "... shall be based on moderate and reasonable rates prevailing in the respective communities where the services are rendered" (C.G.S. 4-67c). The department uses a variety of methods to arrive at rates for physicians and other professionals and fee schedules for ancillary services covered.

As general policy the department will pay the lower of the following:

- the usual and customary charge to the public;
- the fee as contained in the fee schedule published by the department;
- the amount billed by the provider; or
- the Medicare rate.

In reality, if the department has not developed a fee schedule, it generally reimburses providers either at something less than the usual charge, the total amount billed, or the Medicare rate for similar services.

Generally, fees are based upon some percentage or ratio of either the Medicare reimbursement rate or the reasonable and customary charges for the services. The only requirement for updating fees comes from the federal government. If access to physicians is being limited by an inadequate fee schedule -- usually defined as less than 50 percent participation by providers -- than the department is required to reevaluate the fee schedule. The department will then bring fees to within 90 percent of the median prevailing private fees. This has most recently been done for primary care, pediatrics and obstetrics. However, many of the physician fees were set more than five years ago and have not been updated. The program review committee found differences can even result from the location where services are rendered rather than intensity of the services actually used.

The main problem with the department's reimbursement system is that fees are not necessarily based upon resources used, the severity of illness, or the medical treatment provided. Fees are more dependant upon the location where services are received. Many fees have gone unchanged for years while others, such as fees for family planning clinics and outpatient clinics, are required by statute to be updated yearly. This causes an inequity among different providers of health care services and has resulted in a complex rate-making system that lacks a rational pricing policy. The program review committee found that updating thousands of fees is a cumbersome and inefficient process for the department.

Inpatient Hospital Rate-Setting. Determining hospitals rates is another major responsibility of the department. The rate-setting methodology is based upon a per case amount

to be paid for each hospital stay. The per case amount may vary by hospital but does not vary by illness, procedure, or diagnosis. There is an adjustment for length of stay, but the amount paid is capped based upon an overall average number of days.

The division prospectively sets a cap on the amount it will pay a hospital to cover operating costs incurred in treating a Medicaid patient. Each hospital's cap is based upon its 1982 reasonable inpatient operating cost per Medicaid discharge trended forward by an update factor. Thus, 1994 inpatient rates have been updated by an inflation factor each year since the 1982 base rate. The inflation factor was established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and updated annually by the federal Health Care Financing Administration (HCFA).

As noted earlier in this report (see Table II-4 on page 16) Medicaid pays around 45 percent of the state average for operating expenses per hospital case. There is a substantial variation between hospitals' operating expenses and the Medicaid payment. The Medicaid payments can be as high as 80 percent of a per patient operating expense, in case of Winsted Hospital, or as low as 19 percent at New Milford Hospital. This disparity has resulted in a lawsuit filed by the Connecticut Hospital Association against the state of Connecticut over the department's rate-setting methodology (Connecticut Hospital Association, Et. Al. v. William O'Neill, Et. Al.).

The court challenge resulted in the U.S. District Court recently ruling Connecticut's Medicaid reimbursement system invalid. The state has appealed the judge's decision and the case is currently under review. The challenge is based upon a 1980 federal amendment to Medicaid law, known as the Boren Amendment, which says that reimbursement rates should be reasonable and adequate to meet costs incurred by "efficiently and economically" operated facilities. The judge found that the department had failed to establish a connection between the operational costs of hospitals and the reimbursement rates under the state system.

The department's system for hospital reimbursement illustrates the problems inherent within the rate-setting methodology. The state's system of Medicaid payments makes no adjustment for case severity nor does not take advantage of efficiencies in hospital operations that have occurred over the years. Rather payments are based upon historical rates, established in 1982, that may no longer represent current system costs.

The department needs to move to a reimbursement system based on resources consumed rather than arbitrary and antiquated fee schedules and hospital payments. The idea of resource cost-based relative value systems is to measure the work input that goes into performing various health services. It can provide a rational and systematic approach from which to devise a payment structure. The department will be increasingly challenged by outside groups and organizations over its current fee-system and will have difficulty defending it. Most importantly, as the department contracts with pre-paid health plans it will need a rational basis for determining capitated rates. The development of the capitated rate will be crucial to the proper functioning of the Medicaid program and critical to state's efforts to reduce Medicaid costs. The

department must know the level of resources being consumed by its clients and have the ability set prices accordingly. This can not be achieved under the current reimbursement system which has no connection to the health care resources consumed by clients.

The Legislative Program Review Committee recommends the department adopt a resource-based relative value system for the purposes of reimbursing health care providers and services. In addition, the department shall adopt a prospective payment system based upon diagnostically related groups for inpatient hospital payments. Each system shall be implemented by January 1, 1996.

Each system allows for a more accurate accounting of health services used. Once established, each system applies a relative value to the amount of resources consumed and the department will only have to determine a single dollar value to be applied the relative weight. This will result in a simpler method for determining reimbursements as well as allowing fees to be kept current based upon the funds available to the department.

Both systems are currently in use under the federal Medicare program. The Medicare prospective hospital payment system, based on diagnostically related groups, was implemented in 1983 and has undergone continual adjustment. In 1989, Congress required Medicare to adopt fee schedules for physician services based on a resource-based relative value scale. Implementation of the new reimbursement system based on relative values began in 1992 and full implementation is expected by 1996. Connecticut can benefit from the work done by the federal government concerning Medicare payment systems.

State-wide Health Insurance Purchasing Cooperative

The state of Connecticut has the unique opportunity to create a powerful health insurance purchasing cooperative by combining the purchasing power of state employees, their families, and retirees with Medicaid beneficiaries. Such an entity would be responsible for negotiating with managed care health plans to provide insurance for 350,000 lives. Creating a purchasing pool of this size would have a substantial impact not only in containing state health care expenditures but also at enhancing marketplace competition.

Conceptually, the reason for creating a purchasing cooperative is to establish a large purchasing pool that negotiates with health plans for the highest quality coverage at the lowest price. The pool's massive buying power generates competition among health plans, which results in lower prices and improved quality. A purchasing cooperative operates by establishing two levels of choice. First, the agency evaluates health plans interested in offering services to members and contracts with some, but not all, plans based upon a competitive bidding process. Once a cooperative selects several cost-effective plans, employees become involved in the second level of choice. In this second step, a purchasing cooperative would provide members with information on each plan. Members then select the plan that best meets their health care needs.

Although a primary responsibility of a cooperative would be negotiating and selectively contracting with plans, it also would have several other duties. Purchasing cooperatives would perform, at a minimum, the following functions: 1) enrolling members; 2) collecting and distributing premiums; 3) establishing specifications for contracting of health plans competitively; and 4) providing consumer information on cost and quality of competing plans.

The state of Connecticut is a significant purchaser of health services, providing health insurance to over 130,000 current and retired employees and their families. In the early 1980s, the state, through a collective bargaining agreement, created the Health Care Cost Containment Committee to examine issues related to benefit plans and the cost of providing care. The committee, composed of labor and management personnel, was responsible for enrolling all employees into managed health care plans. The committee established criteria for health insurance plans and received bids. Selections were made among competing plans, contracts were awarded, and employees were then given the opportunity to choose the plan they preferred.

The Medicaid managed care initiative will enroll over 220,000 Medicaid recipients into managed care health plans under contract to the Department of Social Services. Similar to state employees, Medicaid clients will be offered a choice among competing plans, based upon the department's initial selection. Selection of health plans will be based a plan's ability to serve the needs of Medicaid recipients.

The fundamental process of procuring managed care health services for state employee health plans and Medicaid pre-paid health plans is similar. For instance, many of the same functions including negotiating with health plans on both cost and quality issues, will be duplicated within the two agencies. Given this comparability, as well as the expertise needed to negotiate, evaluate, and select among health plans, responsibility for health services could be combined into a single state entity. This would create a large purchasing pool with significant market influence that could provide a cost-effective means of securing health services.

The Legislative Program Review Committee recommends that the Comptroller of the state of Connecticut, with the assistance of the Department of Social Services and the Health Care Cost Containment Committee, conduct a study of the feasibility of creating a health insurance purchasing cooperative for state employees, their families, retirees, and Medicaid beneficiaries. The comptroller shall report her findings to the General Assembly by February 1, 1996.

Numerous examples of health insurance purchasing cooperatives operate throughout the United States, and more recently, a few have been created in Connecticut to serve the private sector. One of the most successful and largest organizations operating as a working model of a health insurance purchasing cooperative is the California Public Employees Retirement System (CalPERS). The program is open only to public employers (state, municipal, county, quasi-public, or special district) and has over 920,000 members with premiums of $1.3 billion. Through negotiation and selective contracting with health plans, CalPERs has succeeded in controlling costs over the last two years. In 1992 their premium increase was only 6.2 percent

when health care inflation was running at 12 to 13 percent in California -- an estimated savings of $90 million. CalPERS has kept its total premium increases over the past three years to 6.4 percent compared to the national average of 30.1 percent.

If Connecticut could create a similar purchasing cooperative and match its cost containment success the savings to the state's budget will be significant. One possible way to achieve this would be to combine the state employee population with Medicaid recipients thereby increasing the state's influence and market clout. Competition for providing coverage for large organized groups of individuals has already had a profound effect on the health care market in Connecticut and having the state as a major participant would further the influence competition has on reforming health care.

Appendix A

Federal Waivers Needed for Medicaid Managed Care

Through a federal waiver process, states' may be allowed to use innovative methods for delivering or paying for Medicaid services. Without a waiver, Medicaid law requires that recipients have freedom of choice of providers, and that all state plan services be available in equal amount, scope, and duration. The Omnibus Budget Reconciliation Act of 1981 gave states greater freedom to design managed care health plans under section 1915(b) of the Social Security Act. This provision allows states to limit recipients to certain providers if the managed care arrangement can be shown to be cost-effective. In implementing managed care health plans, the goal is to reallocate resources from expensive, and often inappropriate utilization, to primary and preventive care.

There are three statutory provisions for which 1915(b) waivers have most frequently been granted. The first is freedom-of-choice, the requirement that recipients be able to obtain covered services from any qualified provider willing to accept Medicaid reimbursement. Waiver of freedom-of-choice provisions has let states mandate enrollment in managed care health plans. The other two provisions waived are comparability and statewideness, the requirements that the scope of covered services be the same for all categorically needy beneficiaries and the Medicaid program operate uniformly throughout the State. Waiver of these requirements has permitted states to target particular groups of recipients.

In order for the Health Care Financing Administration (HCFA) to approve a 1915(b) waiver application, a state must demonstrate that its proposed program will be cost-neutral and that restrictions established by the waiver will not impair access to providers. Waivers are granted for two years, but may be renewed after a reapplication process.

In addition to the 1915(b) waiver, HCFA allows states to experiment with new approaches to managing Medicaid recipients through research and demonstration projects authorized under section 1115(a) of the Social Security act. This waiver, differs from the section 1915(b) waiver in that states are given greater freedom to depart from usual federal requirements and may receive federal financial participation for expenditures not usually eligible. A waiver authorized under section 1115(a) is much more difficult for states' to obtain since a formal research design and methodology is required and there are no specific limits on total expenditures.

Other states. Connecticut is one of the last states to enroll their Medicaid population into managed care health plans. By 1992, over 3.6 million residents in 36 states were enrolled in health plans, accounting for about 12 percent of all Medicaid recipients. This number will most likely increase significantly as states become more aggressive in implementing managed care.

Although several states are moving into managed care, each has designed a program that meets the needs of their own populations. Some states have sought to quickly provide universal access to health care and define a minimum set of benefits, while other states have favored an incremental approach.

Table A-1 provides a profile of four states which have received section 1115(b) waivers. The table shows wide variation in the number of individuals enrolled, eligibility thresholds, and scope of benefits available. However, one similarity among these states is that all have increased enrollment in managed care health plan and expanded eligibility to populations not previously covered. A brief profile of these states is presented below.

Hawaii. Hawaii recently received a federal waiver to operate Health QUEST, a health reform program designed to combine a large portion of the Medicaid population and all low- and moderate-income members of the State Health Insurance Program (SHIP) under a managed care delivery system. This will establish a single purchasing pool of 150,000 individuals and will be used to expand access to health services and contain costs.

Comprehensive benefits to individuals with incomes up to 300 percent of the federal poverty level will be provided. Individuals below 133 percent of the federal poverty level will receive health care free of charge; while those above would contribute based on a sliding fee schedule. One of the key elements of QUEST is that eligibility is based only on income, not on assets.

Oregon. The Oregon Health Plan will expand health care coverage for low-income citizens not previously eligible for Medicaid by prioritizing health care services and determining which will be covered under a basic benefit package. The plan provides for private insurance reform, employer coverage, managed care, and restructured Medicaid benefits for Medicaid-eligible and the uninsured. Under the plan, eligibility for Medicaid will be expanded to persons up to 100 percent of the poverty level. In addition, coverage is guaranteed for uninsured working persons via an employer "play or pay" component. By January 1998, employers will be required to provide insurance or will have to pay into a state insurance pool.

Rhode Island. Eligibility for health care benefits will be expanded under the Rite Care program. All enrollees in the program will receive care from prepaid health care plans and an enhanced benefit package of primary and preventive services will be available. The program extends eligibility to pregnant women and children under six with incomes up to 250 percent of the federal poverty level; however those with incomes between 185 and 250 percent will be responsible for a portion of the cost.

Tennessee. In late 1993, following federal approval of Tennessee's waiver, the governor issued an executive order replacing Medicaid with TennCare effective January 1, 1994. The goal of the program is to enroll all Medicaid eligible individuals, as well as low-income individuals ineligible for Medicaid, into managed care plans. Sliding-scale premiums and deductibles are required of those whose household income is greater than 100 percent of the

federal poverty level. From the beginning, the implementation of this program has been extremely controversial. The speed in which the state tried to implement the program, as well as limited experience with managed care organizations in the state, alienated many providers and created numerous problems. As a result, a lawsuit has been filed by the Tennessee Medical Association (TMC) and a decision has yet to be rendered.

Arizona. Arizona has received federal funding under a demonstration waiver since 1982 for an alternative medical assistance program for low-income individuals, called Arizona Health Care Cost Containment System (AHCCCS). Prior to this time, Arizona did not participate in any federal-state Medicaid program. The program is statewide, competitively bid, and capitated for all Medicaid recipients, as well as for the medically needy. Under the program there is no fee-for-service option. Except in two rural counties, at least two plans compete in every community. Individuals select their plan, and if no choice is made they are assigned to the lowest cost plan. (Not shown in table 4).

Table A-1. Major Features of State Medicaid Research and Demonstration Waiver Programs.

State Program Name & Start Date	Est. # of New Enrollees	New Eligibility Categories & Income Limits	Managed Care	Benefits	Cost Sharing	Other Features
Tennessee TennCARE (1/1/94)	500,000 Total enrollment of Medicaid and others capped at 1.5 million	Uninsurable people with pre-existing health conditions, and uninsured; no income cap, but cost sharing based on income level	All enrollees will be covered by one of 12 contracted HMOs or PPOs at risk for all benefits in the standard set	Similar to Medicaid, but without its limits on acute care episodes. No co-payments or deductibles for preventive care.	Premiums, deductibles, & copays for those with family income greater than 100% of FPL.	Special managed care plans for children in custody and the chronically mentally ill.
Oregon (Oregon Health Plan - Medicaid expansion) 2/1/94	120,000	All those in families with incomes below 100% FPL; for now, excludes people over age 65, blind, or disabled, and children in foster care (application pending)	Enrollees must sign up with one of 16 capitated health plans or with a primary care case manager	Expands dental care, hospice, drugs and physical exams. Excludes coverage for 130 (of 696 total) conditions where treatment is less effective or deemed low-priority.	None	Amendment submitted that would add mental health & substance abuse services and aged, blind, and disabled groups.
Rhode Island (Rite Care) 4/1/94	10,000 (in addition to 65,000 AFDC- eligible women and children	Pregnant women and children under age 6 with family incomes below 250% FPL	Must enroll in prepaid, capitated health plans under contract to state.	Medical, dental, and mental health care, including primary and preventive care; enhanced services must also be provided (e.g. outreach, nutrition counseling, smoking cessation).	Co-pays or premiums for those with income over 185% but under 250% of FPL; copays for unauthorized emergency room use by those with income under 185% FPL.	Pregnant women who lose eligibility 60 days post-partum can enroll in 2-year family planning program.
Hawaii (Health QUEST)	No new enrollees; about 31,000 now qualify for state programs other than Medicaid.	All those with incomes up to 300% of FPL, including those currently eligible for AFDC, General Assistance-Medical, and State Health Insurance Program; no asset test.	All care provided via capitated health plans under contract (5 qualified to date); separate plans for dental and mental health.	Standard benefit package includes all services covered under state Medicaid program	Premium contributions and copayments, except for children under age 19 and pregnant women.	All three public assistance programs will be jointly purchased and administered.

Source: State Initiatives in Health Care Reform, Alpha Center, Number 6, May/June 1994.

APPENDIX B

AGENCY RESPONSE

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

25 SIGOURNEY STREET • HARTFORD, CONNECTICUT 06106-5033

January 27, 1995

L. Spencer Cain
Chief Analyst
Legislative Program Review and Investigations Committee
State Capitol - Room 506
Hartford, CT 06106

Dear Spencer:

This is in response to recommendations contained in the final report on Medicaid Health Services in Connecticut as adopted by the Legislative Program Review and Investigations Committee.

1. ***Commissioner of Department of Social Services is required to enroll the entire Medicaid population, excluding long term care, into managed care pre-paid health plans. DSS should begin enrolling Medicaid clients into health plans effective July 1, 1995; and, all health services for Medicaid clients, excluding long term care should be provided through pre-paid health plans by December 31, 1997.***

   DSS is moving ahead to implement its managed care program for AFDC and related groups scheduled for July 1, 1995. The Federal Waiver application has been submitted to HCFA and final applications for managed care plans to participate in the program will be made available in early February. Certification of health plans will begin in April with contracts scheduled to be finalized in May. Full coverage of this population is expected to be achieved by December, 1996.

   The potential to enroll general assistance recipients is currently being assessed.

   OPM and the Department have begun preliminary discussions on approaches to enroll additional categories of Medicaid eligibles. This will require special planning given the risk status of these individuals and the possible need to apply for additional waiver authority under 1115 (Research and Demonstration).

   The goal of "full" managed care penetration of the Medicaid population by December 1997, excluding long term care, is theoretically achievable; but, will require significant resources and a priority commitment by both the Executive

and Legislative branches.

2. ***DSS shall establish a Managed Care Division within Health Care Financing. Further, this division should be responsible for all aspects of the managed care program; and, shall contain a quality assurance unit.***

DSS has begun the work necessary to support the new tasks which are part of managed care.

In the short term, these include the necessary functions of contract management for the health plans, enrollment broker and QA contractor; plan oversight and evaluation relative to access and quality, monitoring and oversight in conjunction with the Insurance Department. The Department must also begin to develop a program design for placing the SSI and other coverage groups into managed care plans. Given the fact that the Department will be operating both a managed care program and continuing fee-for-service for non-enrolled groups; significant aspects of the quality monitoring function will need to be carried out by our Medical Operations Unit.

In the long term, Health Care Financing will need to be completely reorganized as we transition from a claims payor and regulator to a proactive purchaser of care accountable for access, quality, health outcome, efficiency and effectiveness. Ultimately, Medicaid's function will be to plan and administer contracts with private organizations and the structure will need to be redesigned in this light. Managed Care will not be just a unit or division. It will be what Medicaid does.

3. ***DSS should develop a "report card" system to compare performance levels among health plans. The report card is to be based on four areas of measurement and will be published annually.***

Some of the data elements which would be included in a "report card" system will be in place in "raw" form with the introduction of managed care, i.e., encounter data requirements, recurrent reporting instruments for immunizations, prenatal and maternity care and behavioral health. These along with data on quality, customer satisfaction etc. need to be integrated into an overall system of performance appraisal. HEDIS and QARI systems represent approaches that can be utilized.

As we understand it, the UCONN Data Institute is responsible to the State for ultimately developing measures of health plan performance and we are prepared to work with them and OHCA , and I hasten to add others as necessary, in this regard.

4. ***DSS will provide the Connecticut Health Care Data Institute with a person level Medicaid data base. This would be accomplished through an agreement and facilitated through a "steering" committee.***

   DSS staff is currently working with both OHCA and the Data Institute to define data base requirements including data management and managed care benchmark measures. Our collective view is to convene a task force or work group comprised of DSS, OHCA, Data Institute, other state agencies, health plans and other to develop data definitions, uniform reporting tools, standard protocols and to deal with issues of confidentiality.

5. ***DSS should contract with the Department of Insurance (DOI) for approval and ongoing oversight of all pre-paid health plans serving Medicaid recipients.***

   DSS is anxious to develop a structured agreement with DOI concerning initial plan certification and ongoing monitoring. DOI has raised an issue of resource constraints. DSS expects that this issue can be resolved.

6. ***DSS should adopt a resource based relative value system (RBRVS) to reimburse providers of health care services. The Department should also adopt a prospective payment system predicated on DRGs for inpatient hospital services. Each system should be adopted by January 1, 1996.***

   DSS is proceeding with the development of RBRVS. The MMIS system as currently configured cannot perform this task. Implementation will occur once the new AIM system is operational. It is scheduled to go on-line in January 1996.

   DSS has several concerns relative to adopting a DRG approach to hospital payments. Implementing a DRG system would require a significant resource commitment and in the current environment we are not clear whether this option is possible or desirable. First, it is not known what the final outcome of CHA vs. O'Neil will be both in terms of payment levels and methodology. Second, if the entire Medicaid population, exclusive of long term care, is to be transitioned into managed care with plans responsible for paying inpatient care costs it is questionable why we would need a DRG system.

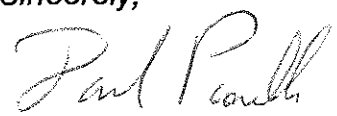
7. ***The Comptroller, with the assistance of DSS and the Health Care Cost Containment Commission, shall conduct a feasibility study on a health insurance purchasing cooperative for state employees, their dependents, retirees and Medicaid beneficiaries. The Comptroller's findings are to be submitted by February 1, 1996.***

DSS will be pleased to participate in the study. However staff constraints will prevent us from taking any lead responsibilities.

Thank you for the opportunity to comment on the recommendations. The recommendations we think are appropriately forward looking although the exact timing is subject to change. You and your staff are to be commended for preparing a very thorough analysis of a complex program and set of issues.

We have appreciated working with you on the study and look forward to future contacts. Please call me at 424-5168 or Jim Gaito at 424-5137 if you have any questions.

Sincerely,



David Parrella, Acting Deputy Commissioner

cc: Patricia Giardi, Acting Commissioner
James Gaito, Medical Administration Manager